APPENDIX A

Case No: 97-5232

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

FILED
July 16, 1998
LEONARD GREEN, Clerk

PEOPLE FIRST OF TENNESSEE, on behalf of its members; CARL BEARD, nfr Wendy Kurland; SANDRA HOWARD; HERMAN WALTER RUNIONS, nfr Sarah R. Todd; HARVEY RICHARD WATSON, nrf Bonita Scott; CLARENCE WILSON, nfr Wilma Williamson; STEVELYN DANIEL TUCKER; KEITH COLLINS
Plaintiffs - Appellees

v.

ARLINGTON DEVELOPMENTAL CENTER; NED MCWHERTER; MONA REEVES-WINFREY, sued in her official capacity as superintendent of Arlington Developmental Center; MENTAL HEALTH, TN; EVELYN C. ROBERTSON, JR., sued in his official capacity as commissioner of Mental Health and Mental Retardation; MARJORIE NELLE CARDWELL; TENNESSEE HEALTH DEPARTMENT; RUSSELL WHITE, sued in his official capacity as commissioner of Health; MANNIE MARTIN, sued in his official capacity as director of Bureau of Medicaid; TENNESSEE DEPARTMENT OF HUMAN SERVICES;

ROBERT GRUNOW, sued in his official capacity as commissioner of Human Services; BETTY GAYLE, sued in her official capacity as assistant commissioner for Social Services; PATSY MATTHEWS, sued in her official capacity as assistant commissioner for Rehabilitation Services

Defendants - Appellees

PARENT-GUARDIAN ASSOCIATION OF ARLINGTON DEVELOPMENTAL CENTER

Intervenor-Appellant

BEFORE: KRUPANSKY, NELSON and BATCHELDER, Circuit Judges.

Upon consideration of the motion filed by the appellant to stay the mandate pending the filing of a Petition of Writ of Certiorari,

It is ORDERED that the motion be, and it hereby is, GRANTED.

The mandate is stayed for thirty days from this Order unless the Court is advised that the Petition for Writ of Certiorari has been filed.

ENTERED BY ORDER OF THE COURT

/s/_____

Leonard Green, Clerk

APPENDIX B

97-5232

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

FILED
July 1, 1998
LEONARD GREEN, Clerk

PEOPLE FIRST OF TENNESSEE, ON BEHALF OF ITS MEMBERS, ET AL., Plaintiffs-Appellees,	)	**ORDER**
v.	)	
ARLINGTON DEVELOPMENTAL CENTER, ET AL., Defendants-Appellees,	)	
PARENT-GUARDIAN ASSOCIATION OF ARLINGTON DEVELOPMENTAL CENTER, Intervenor-Appellant.	)	

BEFORE: KRUPANSKY, NELSON, and BATCHELDER, Circuit Judges.

The court having received a petition for rehearing en

banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/_____
Leonard Green, Clerk

APPENDIX C

FILED
May 7, 1998
LEONARD GREEN, Clerk

No. 97-5232

NOT RECOMMENDED FOR FULL-TEXT PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ON APPEAL FROM THE
UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT
OF TENNESSEE

PEOPLE FIRST OF TENNESSEE, on behalf of its members; CARL BEARD, nfr Wendy Kurland; SANDRA HOWARD; HERMAN WALTER RUNIONS, nfr Sarah R. Todd; HARVY RICHARD WATSON, nfr Bonita Scott; CLARENCE WILSON, nfr Wilma Williamson; STEVELYN DANIEL TUCKER; KEITH COLLINS,
Plaintiffs-Appellees

v.

ARLINGTON DEVELOPMENTAL CENTER;

NED MCWHERTER; MONA REEVES-WINFREY, sued in her official capacity as Superintendent of Arlington Developmental Center; MENTAL HEALTH, TN; EVELYN C. ROBERTSON, JR., sued in his official capacity as Commissioner of Mental Health and Mental Retardation; MARJORIE NELLIE CARDWELL; TENNESSEE HEALTH DEPARTMENT; RUSSELL WHITE, sued in his official capacity as Commissioner of Health; MANNIE MARTIN, sued in his official capacity as Director of Bureau of Medicaid; TENNESSEE DEPARTMENT OF HUMAN SERVICES; ROBERT GRUNOW, sued in his official capacity as Commissioner of Human Services; BETTY GAYLE, sued in her official capacity as Assistant Commissioner for Social Services; PATSY MATTHEWS, sued in her official capacity as Assistant Commissioner for Rehabilitation Services,

Defendants-Appellees,

PARENT-GUARDIAN ASSOCIATION OF ARLINGTON DEVELOPMENTAL CENTER,

Intervenor-Appellant.

Before: KRUPANSKY, NELSON, and BATCHELDER, Circuit Judges.

PER CURIAM. This is a class action involving alleged violations of the constitutional rights of developmentally

disabled residents of a state institution. The parents and guardians of a number of the residents intervened to oppose class action status, but the class was certified and the case was ultimately resolved in a settlement approved by the district court. The intervenors have appealed, asking us to overturn the certification of the class, the approval of the settlement, and three related rulings. We find no basis for doing so.

I

In December of 1991 an entity called "People First of Tennessee" brought suit against the Arlington Developmental Center ("ADC"), seeking injunctive and declaratory relief on behalf of ADC's residents. ADC is an institution owned and operated by the state of Tennessee to care for mentally retarded people. Approximately 400 individuals were housed at ADC when the suit was filed.

People First of Tennessee is a non-profit advocacy organization composed of (and allegedly governed by) people with disabilities. Joining with six individual ADC residents,[1] the organization sued ADC and other state agencies and officials[2] on claims that residents of the institution were being deprived of basic care and medical treatment, habilitation and training programs, adequate behavior and nutritional management, physical therapy, adequate communication services, and rights of personal choice, privacy, and freedom

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[1] The initial complaint included four individual plaintiffs, but an amended complaint, filed in February of 1993, added two more. The plaintiffs will be referred to collectively as "People First."

[2] The defendants will be referred to collectively as "the state."

of association. It was also alleged that the residents suffered frequent injury and abuse, unnecessary restraint, and loss of skills caused by inadequate therapy programs and inadequate staffing. Some of People First's claims were based on the "substantive" component of the Due Process Clause of the Fourteenth Amendment, others were based on the First Amendment as made applicable to the state by the Fourteenth Amendment, and still others had a statutory basis.

Acting on behalf of relatives and guardians of ADC residents, the Parent-Guardian Association of Arlington Developmental Center ("PGA") moved to intervene. PGA objected to People First's representation of the class and expressed concern that People First would eventually seek to close ADC.

On January 26, 1993, the district court granted PGA's motion to intervene and dismissed many of People First's claims. The court's ruling left certain due process and freedom of association claims to be adjudicated, but none of the statutory claims.

While the class action was pending, the federal government sued the State of Tennessee under the Civil Rights of Institutionalized Persons Act, asserting claims similar to those advanced in the *People First* case. *United States v. Tennessee,* 92-2062 M1/A (W.D. Tenn.) (hereinafter referred to as "the *U.S.* case"). The *U.S.* case went to trial in the fall of 1993, and the court found that constitutional rights of ADC residents were indeed being violated. On September 2, 1994, the court entered a 54-page remedial order. Extensive training and monitoring programs were mandated, and the state was directed to reduce the ADC population to

200 residents. The reduction was to be accomplished by transferring appropriate residents to community living arrangements designed to meet individual needs.

At this point the court entered a temporary stay of proceedings in the *People First* case. All motions in this case were denied without prejudice, and the parties were instructed to review the Remedial Order and then renew any motions they wished to press further. Among the pending motions was one in which PGA had moved to consolidate the class action with the *U.S.* case. PGA did not renew the consolidation motion.

People First renewed its motion for class certification, and on September 26, 1995 -- over objection from PGA -- the court certified a plaintiff class. The class included

> "all persons who on or after December 12, 1989, have resided, or are residing at the Arlington Developmental Center; all persons who have been transferred from Arlington Developmental Center to other settings such as intermediate care facilities or skilled nursing facilities but remain defendants' responsibility; and all persons at risk of being placed at Arlington Developmental Center."

The court went on to hold that the relief granted in the *U.S.* case disposed of People First's due process claims. The court adopted the findings of fact from the *U.S.* case and entered the remedial order from that case "as the final order in this matter as a remedy for defendants' violation of plaintiffs' Fourteenth Amendment rights." The First

Amendment claims remained at issue.

Meanwhile, in June of 1995 -- almost 30 months after it had been allowed to intervene -- PGA moved for leave to file a complaint against the state alleging that the placement of residents in community living arrangements would be harmful to the residents so placed. Treating the complaint as a cross-claim, the court denied the motion as both untimely and inappropriate because no substantive due process issues remained to be decided.

People First and the state settled the remaining issues in January of 1997. Having stipulated to violations of the residents' First Amendment associational fights, the state agreed to develop a right-of-association policy, to train staff members to allow free exercise of the right of association, to implement a program for disciplining staff who violated residents' rights, and to allow "advocates, religious organizations, and community organizations reasonable opportunity to communicate with residents and allow[] residents the opportunity to participate in community activities."

PGA objected to the settlement, contending that there should have been no stipulation without proffered evidence and expressing concern that the settlement would limit parental access to residents. After considering the objections and other factors, the district court approved the settlement as fair, adequate, and reasonable.

PGA now appeals the class certification and the approval of the settlement, as well as the denial of the motion to consolidate, the denial of the motion for leave to file a

cross-claim, and the entering of findings from the *U.S.* case.

II

Most of the challenged rulings are subject to review under an abuse of discretion standard. See *Weaver v. University of Cincinnati,* 970 F.2d 1523, 1531 (6th Cir. 1992), *cert. denied,* 507 U.S. 917 (1993) (class certification); *Bailey v. Great Lakes Canning, Inc.,* 908 F.2d 38, 42 (6th Cir. 1.990) (class settlement); *Cantrell v. GAF Corp.,* 999 F.2d 1007, 1011 (6th Cir. 1993) (motion to consolidate); *Shearson/Am. Express, Inc. v. Mann,* 814 F.2d 301,308 (6th Cir. 1987) (counterclaim). The entry of final judgment on the substantive due process claims is reviewed *de novo.* See *Parrett v. Am. Ship Bldg. Co.,* 990 F.2d 854, 857 (6th Cir. 1993).

A

The propriety of class certification in a case such as this, where injunctive and declaratory relief has been sought with respect to allegedly unlawful conditions at a state institution, turns in part on Fed. R. Civ. P. 23(b)(2).[3] Before certifying a class under Rule 23(b)(2), the district court must conduct a rigorous analysis to determine whether

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[3] Rule 23(b)(2) allows class actions, under certain conditions, in cases in which "the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole."

> "(1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a).

Considering each of these provisions, the district court concluded that the class certification requirements of Rules 23(a) and 23(b)(2) were met. At the time of certification ADC had approximately 385 residents. Although residents' medical and habilitation needs varied, the court found that "whether defendants are prohibiting residents from associating with certain individuals in violation of their First Amendment rights" was a question common to the class. The claims against the state arose from the same patterns and practices, moreover, and were based on the same legal theory. See *In re Am. Med Sys., Inc.*, 75 F.3d 1069, 1082 (6th Cir. 1996) (discussing the typicality requirement). Finally, the court determined that the named plaintiffs would fairly and adequately protect the interests of the class. The plaintiffs' counsel was qualified and competent to prosecute the action vigorously, and there was no evidence, that People First had interests that were antagonistic to those of the other residents. See *id.*, at 1083; *Senter v. General Motors Corp.*, 532 F.2d 511,525 (6th Cir.), *cert. denied,* 429 U.S. 870 (1976).

PGA's primary objection to class certification was that many of the residents' parents and guardians opposed representation by People First. There were thus conflicts of interest between the representative and the class, according to

PGA, and there were not enough residents allied with People First for the class to be numerous.

Noting that Tennessee law does not give guardians exclusive control over the exercise of their wards' legal rights, the district court rejected this argument. We find no abuse of discretion in this or any other aspect of the district court's treatment of the class certification issue. We cannot say the certification was improper.[4]

B

Where settlement of a class action is proposed, Fed. R. Civ. P. 23(e) directs the court to hold a hearing to determine whether the proposed settlement is "fair, adequate, and reasonable, as well as consistent with the public interest." The district court held the requisite heating in this case, after appropriate notice, and carefully considered (among other things) the likelihood of success on the merits, the complexity of the litigation, the stage of discovery, the opinions of the parties' counsel, the concerns of the class members and other interested parties, and the public interest. *Cf. Williams v. Vukovich,* 720 F.2d 909, 922-924 (6th Cir. 1983). The settlement was held to be fair, adequate, and reasonable in light of the pertinent factors.

We find no abuse of discretion in the court's decision.

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[4] Responding to PGA's appeal of the certification, the state itself questioned certain aspects of the class definition. Inasmuch as the state has not appealed, however, these matters are not properly before the court.

The settlement assured that residents' First Amendment rights would be protected without the expense and effort of a trial. PGA's concerns about impairment of parental access to residents are unsupported; the language of the settlement protects residents' rights to associate with others, but in no way abridges the rights of parents and guardians.

C

As to the denial of PGA's motion to consolidate, we note that the motion was denied without prejudice. PGA never having filed a new motion to consolidate, as the court invited it to do, we find it hard to see how PGA can complain of the failure to consolidate. PGA was allowed to intervene in the *U.S.* case, in any event, and the concerns about community placement were more properly addressed there.

As to the denial of PGA's motion for leave to file a complaint against the state, we note that the motion came some two and one-half years after PGA's intervention. The proposed complaint, moreover, addressed only the due process issues dealt with in the *U.S.* case. The district court did not abuse its discretion in denying the motion.

Finally, PGA challenges the court's entry of findings from the U.S. case, a proceeding in which PGA maintains that its interests were not represented. The question, however, is whether the state -- the defendant against which the remedial order was directed had a full and fair opportunity to contest the allegation that it had violated the substantive due process rights of the ADC residents. The court properly held that the state had such an opportunity. The remedial order in the *U.S.* case addressed the conditions underlying People

First's due process claims, and collateral estoppel barred relitigation of the due process issues in this case. PGA cannot effectively challenge the remedial order in the *U.S.* case as an intervenor here.

AFFIRMED.

APPENDIX D

CASE NO: 92-2213-M1/V

FILED
January 7, 1997
ROBERT R. DI TROLIO
CLERK, U.S. DIST. CT.
W.D. OF TEN, MEMPHIS

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

PEOPLE FIRST OF TENNESSEE)
on behalf of its members,)
et al.)
)
VS.)
)
THE ARLINGTON DEVELOPMENTAL)
INVESTIGATION, et al.)
)
PARENT GUARDIAN ASSOCIATION OF)
THE ARLINGTON DEVELOPMENTAL)
CENTER)
_____/

JUDGMENT IN A CIVIL CASE

DECISION BY COURT. This action came to consideration before the Court. The issues have been considered and a

decision has been rendered.

IT IS SO ORDERED AND ADJUDGED that In accordance with the Order Approving Settlement of Class Action entered on January 6, 1997, the Court approves the proposed settlement and enters judgment in accordance with the settlement agreement. The Court shall retain jurisdiction over the parties, including all members of the settlement class, and the administration and enforcement of the settlement agreement.

APPROVED:

/s/_____
JON PHIPPS MCCALLA
UNITED STATES DISTRICT COURT

January 6, 1997
Date

/s/_____
ROBERT R. DI TROLIO

/s/_____
(By) Wendy Bachledge-Ellis
Deputy Clerk

APPENDIX E

FILED
January 7, 1997
Clerk

No. 92-2213 M1/V

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

PEOPLE FIRST OF TENNESSEE)
on behalf of its members,)
et al.)
Plaintiffs,)
v.)
)
THE ARLINGTON DEVELOPMENTAL)
INVESTIGATION, et al.)
Defendants,)
)
PARENT GUARDIAN ASSOCIATION OF)
THE ARLINGTON DEVELOPMENTAL)
CENTER,)
Intervenor.)

ORDER APPROVING SETTLEMENT OF CLASS ACTION

This matter is before the Court on plaintiffs' and defendants' Proposed Stipulation and Order of Compromise and Dismissal, filed July 29, 1996, and plaintiffs' Motion for Final Approval of the Proposed Settlement Agreement, filed September 13, 1996. For the reasons set forth below, the proposed settlement of the class action is APPROVED.

BACKGROUND

This case was originally filed on December 12, 1991, by five Arlington Development Center ("ADC") residents and by People First of Tennessee. The case was transferred to this Court on March 5, 1992. Plaintiffs alleged that the conditions at Arlington Developmental Center violated the constitutional and statutory rights of the Arlington residents and those at risk of placement there. Plaintiffs sought injunctive and declaratory relief from the conditions at ADC.

On January 26, 1993, the Court dismissed plaintiffs' statutory claims and certain of their First and Fourteenth Amendment claims and granted the Parent Guardian Association's motion to intervene. The remaining First Amendment claims asserted that the defendants violated the plaintiffs' rights to freedom of expression and association by preventing Arlington residents from associating with others, and by preventing the residents from communicating with others of their choice.

Meanwhile, in January, 1992, the United States filed an action against the State of Tennessee under 42 U.S.C. § 1997 et seq, alleging that the state had failed to provide humane conditions and adequate treatment at Arlington Developmental Center. United States v. Tennessee, Civ. No.

92-2062. Each of the parties to the present action were parties to that case. After a lengthy trial, this Court entered judgment against the defendants finding that the conditions at ADC violated the residents' due process rights.

On September 27, 1995, the Court granted plaintiffs' motion for class certification, defining the class as: "all persons who after December 12, 1989, have resided or are residing at the Arlington Developmental Center, all persons who have been transferred to other facilities but who remain the defendants, responsibility, and all persons at risk of being placed in the Center." In addition, the Court granted partial summary judgment on plaintiff's claims under the Fourteenth Amendment relating to care, services, abuse, and neglect in light of the Court's decision in United States v. Tennessee, Civ. No. 92-2062.

As a result of the September 27, 1995 Order, the only remaining issues in the case are the plaintiffs' First Amendment claims. By order dated January 11, 1996, the Court set a trial for these issues to begin on July 29, 1996. On July 29, 1996, however, plaintiffs and defendants filed a proposed stipulation and order of compromise and dismissal under Federal Rule of Civil Procedure 23(e). Parent Guardian Association, the intervenor, opposes the proposed settlement.

The proposed settlement agreement provides:

1. The plaintiffs and defendants acknowledge that past violations of the residents' First Amendment rights did occur. Plaintiff/residents were prevented from communicating, associating and assembling with persons of their choice.

2. According to the proposed settlement, the Defendants will protect the rights of the Plaintiff/residents by:

(a) developing a policy to enable residents to communicate, associate, and assemble with others of their choice both publicly and privately;

(b) telling the staff of the Arlington Developmental Center and agencies who work with the Center about the policy so that staff will not discourage residents from exercising their right to freely communicate, associate and assemble with others of their choice;

(c) establishing a process to discipline staff members who violate the right of residents to freely communicate, associate and assemble with others; and

(d) allowing advocates, religious organizations, and community organizations reasonable opportunity to communicate with residents and allowing residents the opportunity to participate in community activities.

DISCUSSION

Federal Rule of Civil Procedure 23(e) provides that a

class action cannot be settled without court approval.[1] "Three steps are required [for approving a class action settlement]: 1) the court must preliminarily approve the proposed settlement; 2) members of the class must be given notice of the proposed settlement; and 3) a hearing must be held to determine whether the proposed settlement is fair, reasonable and adequate." Reed v. Rhodes, 869 F. Supp. 1274, 1278 (N.D. Ohio 1994) (citing Williams v. Vukovich, 720 F.2d 909, 921-22 (6th Cir. 1983)).

By Order dated August 15, 1996, this Court preliminarily approved the proposed settlement agreement. In that same Order, the Court ordered counsel for the plaintiffs and defendants to mail notice to all class members and other interested parties by Friday, August 30, 1996, at 5:00 p.m. That notice also advised all parties interested in commenting on or objecting to the settlement to submit comments by September 20, 1996, at 5:00 p.m. Likewise, the notice advised all those wishing to participate in the hearing to notify the Court by September 20, 1996, at 5:00 p.m.

On September 27, 1996, the Court held a hearing so that any class member or family member, guardian, or next friend of a class member could comment on the proposed settlement. At that hearing, the Court heard testimony from interested parties and accepted written comments from

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[1] Federal Rule of Civil Procedure 23(e) provides:

> A class action shall not be dismissed or compromised without the approval of the court, and the proposed dismissal or compromise shall be given to all members of the class in such manner as the court directs.

members of the intervenor.

A court should approve a settlement if it is fundamentally "fair, adequate and reasonable, as well as consistent with the public interest." Bailey v. Great Lakes Canning, Inc., 908 F.2d 38, 42 (6th Cir. 1990) (citing United States v. Jones & Laughlin Steel Corp. 804 F.2d 348, 351 (6th Cir. 1986)). In determining whether the proposed settlement is "fundamentally fair, adequate, and reasonable," the court should consider the following factors:

1. Plaintiffs likelihood of success on the merits balanced against the relief offered by the proposed settlement agreement;

2. The complexity, expense, and likely duration of the litigation;

3. The stage of the proceedings and the amount of discovery;

4. The judgment of experienced trial counsel;

5. The nature of the negotiations;

6. The concerns and comments of the class members and other interested parties; and

7. The public interest.

Bronson v. Board of Education, 604 F. Supp. 68, 74-82 (S.D. Ohio 1984) (citing Vukovich, 720 F.2d at 922); accord Granada Investments, Inc. v. DWG Corp., 962 F.2d 1203,

1205 (6th Cir. 1992) (holding that a court should balance "the likelihood of success on the merits, the risk associated with and the expense and complexity of litigation, and the objections raised by class members"). Applying these factors to the present case, the Court finds that the proposed settlement is fundamentally fair, adequate, and reasonable.

1. Plaintiff's likelihood of success on the merits balanced against the relief offered by the proposed settlement agreement.

In their suit, plaintiffs seek to establish that the defendants have deprived the residents of Arlington Developmental Corporation of their First Amendment rights and seek injunctive and declaratory relief against any such future infringements. In the proposed settlement, the defendants stipulate to past First Amendment violations and agree to institute a plan to ensure that no such violations occur in the future. Thus, even if the plaintiffs were to succeed at trial, the plaintiffs could not conceivably obtain more relief than that offered in the proposed settlement. In going to trial, however, the plaintiffs would run the inescapable risk of obtaining no relief. Accordingly, the Court finds that this factor weighs in favor of approving the settlement.

2. The complexity, expense and likely duration of the litigation.

This case was originally filed in December 1991, and has involved costly, time-consuming litigation. Although the trial of the alleged First Amendment violations is estimated to last only one to one and one-half days, if the court were to find a First Amendment violation, remedial hearings would

have to be held and appeals could be taken prior to any resolution of the alleged violations. Consequently, the relief sought by the plaintiffs could be delayed significantly. In contrast, the settlement agreement allows the plaintiffs to enjoy the benefits of the agreement almost immediately. Accordingly, the Court finds that this factor also weighs in favor of approving the settlement.

3. The stage of the proceedings and the amount of discovery completed.

The purpose of considering the stage of the proceedings and the amount of discovery taken is to ensure that plaintiffs had access to sufficient material to evaluate the case and to assess the adequacy of the settlement proposal with an informed judgment of the strengths and weaknesses of their position. See In re General Motors Corp., 846 F. Supp. 330, 334-35 (E.D. Pa. 1993). As noted above, this case was originally filed almost five years ago. Thus, this is not a settlement that was reached in the early stages of litigation without significant consideration or deliberation. In contrast, significant amounts of discovery have occurred and a related trial has exposed the conditions existing at Arlington Developmental Center. As a result, the parties have been able to make an informed decision about the alleged First Amendment violations and the merits of the proposed settlement. Given the amount of information available to the parties, the Court concludes that this factor weighs in favor of the proposed settlement.

4. The opinion of counsel

In appraising the fairness of a proposed settlement, the

view of experienced counsel favoring a settlement is entitled to significant weight. Thompson v. Midwest Found. Indem. Physicians Ass'n, 124 F.R.D. 154, 159 (S.D. Ohio 1988); Bronson, 604 F. Supp. at 73 (holding that "when significant discovery has been completed, the Court should defer to the judgment of trial counsel who has reviewed the strength of his case"). As noted above, a significant amount of discovery has taken place in this case. In addition, counsel has benefitted from the discovery and trial conducted in United States v. Tennessee. Thus, counsel for both sides was able to fully evaluate the strengths and weaknesses of their respective cases. See Bronson, 604 F. Supp. at 73. Consequently, the Court finds that the extensive discovery conducted in this case and other information available to the parties warrants placing great weight on the opinion of counsel that the settlement is fair, adequate, and reasonable.

5. The nature of the negotiations

There is no indication that the proposed settlement is the product of collusion. Instead, the settlement was the product of' "intense, arms-length negotiations between the parties," Bronson, 604 F. Supp. at 78, after almost five years of litigation. Counsel for the intervenor asserts that the agreement is the product of collusion on the grounds that there is no evidence of any First Amendment violations. In approving a settlement decree, however, "[t]he Court has no occasion to determine the merits of the controversy or the factual underpinning of the legal authorities advanced by the parties." Vukovich, 720 F.2d at 921. The only question before the Court is whether the settlement agreement is fair, adequate, and reasonable. Id. Moreover, even assuming that there were no First Amendment violations, this does not

change the fact that the agreement is fair, adequate, and reasonable. The settlement provides the plaintiff class with the full range of protection sought in their complaint. It is difficult to see how this agreement is the result of collusion when the plaintiff class gets everything it wanted and the opposing parties include the state of Tennessee and various state agencies. This Court notes that there is little doubt that the state of Tennessee is quite capable of protecting itself and its agencies.

Finally, requiring the plaintiffs to prove the existence of the First Amendment violations before settlement would undermine the overriding public policy interest in favor of settlement. See Schaeffer v. Tannian, 1995 WL 871134 at *5 (E.D. Mich. 1995) ("The policy in federal court favoring the voluntary resolution of litigation through settlement is particularly strong in the class action context."). The entire point of a settlement is to resolve the case in a manner acceptable to the parties without an actual in-court determination of liability. Accordingly, the Court finds that the intervenor's objections do not merit a finding that the settlement is not fair, adequate, and reasonable.

6. The concerns and comments of class members and other interested parties.

The Court must also consider any objections to the proposed settlement. Stotts v. Memphis Fire Dep't, 679 F.2d 541, 554 (6th Cir. 1982), rev'd on other grounds sub nom. Firefighters Local Union No. 1784 v. Stotts, 467 U.S. 561 (1984); Bronson, 604 F. Supp. at 78. Although the Court must consider any objections made, the fact that there are objections does not mean that the settlement cannot be

approved. Stotts 679 F.2d at 554. The ultimate issue remains whether the proposed settlement is fair, adequate, and reasonable.

In this case, the Court has received comments from a number of members of the Parent Guardian Association ("PGA") and from ComCare Inc., a court appointed guardian for a number of ADC residents.[2] After careful consideration of all the views expressed both in writing and at the hearing, the Court finds that the settlement is fair, adequate, and reasonable.

One major area of concern voiced by the intervenor is that there was no evidence of any First Amendment infringement. As discussed above, this argument does not prevent the court from approving the settlement.

A second area of concern raised by PGA and ComCare is that the settlement will interfere with the parents' and guardians' rights to represent and speak for their children and wards. The settlement, however, does not strip the parents and guardians of their duties and responsibilities to their children and wards at the Arlington Developmental Center. Instead, the settlement merely provides safeguards to the ADC residents that their First Amendment rights will not be violated by the staff at ADC. The parents and guardians will retain their voice and ability to influence the care of their children and/or wards -- within constitutional constraints of

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[2] By Order dated November 6, 1996, the Court agreed to consider comments submitted by Comcare, Inc., even though the comments were received after the deadline for submitting such comments.

course.

A third area of concern is that the settlement will allow third parties, including advocates, religious organizations, and community organizations, unfettered access to the residents of Arlington Developmental Center. Again, such a concern is overstated. The settlement merely provides that the ADC will allow such parties "reasonable opportunity to communicate with residents." Reasonable opportunity does not mean unfettered access. Instead, the use of the term "reasonable opportunity" recognizes that a policy protecting the First Amendment rights of the Arlington residents cannot be rigidly fixed; rather, it must remain flexible to accommodate the unique needs of the residents while at the same time protecting their First Amendment rights.

A final area of concern surrounds the wording of the settlement decree. In particular, concerns were raised as to the meaning of "discourage" in paragraph 2(b) of the proposed settlement agreement. Once again, a settlement of this kind cannot be reduced to specific and exacting standards. The unique challenges facing both the residents and the staff of ADC require that such a policy remain somewhat flexible.

In sum, although the Court recognizes the thoughtful and heartfelt concern expressed by the parents and guardians of the residents of Arlington Developmental Center, the Court nonetheless finds that the objections raised do not warrant a finding that the settlement is not fair, adequate, and reasonable to the plaintiff class.

7. The public interest

Finally, the Court must consider whether the settlement is in the public interest. Vukovich, 720 F.2d at 923. There is little doubt that the proposed agreement is in the public interest. Not only does the settlement agreement bring an end to nearly 5 years of litigation, but, more importantly, it improves the quality of services provided to the residents of the Arlington Development Center by guaranteeing protection of their constitutional rights under the First Amendment.

CONCLUSION

Having examined and weighed the above factors, the Court concludes that the proposed settlement agreement is fair, adequate, and reasonable. Accordingly, the Court APPROVES the proposed settlement and directs that a judgment, in accordance with the settlement agreement, be entered by the clerk. The Court shall RETAIN jurisdiction over the parties, including all members of the settlement class, and the administration and enforcement of the settlement agreement.

IT IS SO ORDERED this 6 day of January 1997.

/s/_____
JON P. McCALLA
STATES DISTRICT JUDGE

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

FILED
August 15, 1996

No. 92-2213 M1/V

CERTIFIED TRUE COPY
ROBERT R. DI TROLIO
U.S. DISTRICT COURT
WESTERN DISTRICT OF TENNESSEE
/s/_____
DEPUTY CLERK

PEOPLE FIRST OF TENNESSEE; et. al.,)
Plaintiffs,)
)
v.)
)
ARLINGTON DEVELOPMENTAL CENTER)
et. al.,)
Defendants.)
_____/

ORDER

On July 29, 1996, plaintiffs and defendants submitted a proposed stipulation and order of compromise and

dismissal. Intervenor filed an objection to the proposed stipulation and order. Accordingly, on July 30, 1996, the Court conducted a conference by telephone on the issues raised in intervenor's objection. On July 31, 1996, the Court entered an order directing plaintiffs to submit a plan for compliance with Fed. R. Civ. P. 23(e) by 5:00 p.m. on August 6, 1996, and intervenor to submit any comments on plaintiff's plan by 5:00 p.m. on August 13, 1996. On August 6, 1996, plaintiffs submitted a proposed plan for compliance along with a proposed notice of proposed settlement. On August 13, 1996, intervenor submitted comments on plaintiffs' proposed plan.

Under Fed. R. Civ. P. 23(e),

> A class action shall not be dismissed or compromised without the approval of the court, and notice of the proposed dismissal or compromise shall be given to all members of the class in such manner as the court directs.

Upon consideration of the filings of the parties with respect to compliance with Fed. R. Civ. P. 23(e), it appears that the following is necessary to provide proper notice to the class certified by order of September 27, 1995. The proposed stipulation and order of compromise and dismissal attached hereto as exhibit 1 is hereby PRELIMINARILY APPROVED pending final order of the Court after the hearing described hereinafter: The notice of proposed settlement attached hereto as exhibit 2 is hereby APPROVED. Counsel for plaintiffs are hereby ORDERED to arrange to have the notice of proposed settlement published in The Commercial Appeal (Memphis) newspaper on three occasions: 1) once during .the week of

August 25, 1996, to August 31, 1996; 2) once during the week of September 1, 1996, to September 7, 1996; and 3) once during the week of September 8, 1996, to September 14, 1996. Counsel for defendants are hereby ORDERED to provide counsel for plaintiffs a current list of the following by 5:00 p.m. on Friday, August 23, 1996: 1) the names and addresses of all Arlington Developmental Center ("ADC") residents discharged on or after December 12, 1989; 2) the names and address of the family members, guardians, or next friends of all ADC residents discharged on or after December 12, 1989; 3) the names and addresses of the family members, guardians, and next friends of all current ADC residents. Counsel for plaintiffs are hereby ORDERED to mail copies of the notice of proposed settlement via first class mail, postage prepaid, to ADC residents discharged on or after December 12, 1989, and to the family members, guardians, or next friends of ADC residents discharged on or after December 12, 1989, by 5:00 p.m on Friday, August 30, 1996. Counsel for defendants are hereby ORDERED to deliver a copy of the notice of proposed settlement to each current ADC resident by 5:00 p.m. on Friday, August 30, 1996. Counsel for plaintiffs are hereby ORDERED to mail copies of the notice of proposed settlement via first class mail, postage prepaid, to family members, guardians, or next friends of all current ADC residents. Counsel for defendants are hereby ORDERED to mail copies of the notice of proposed settlement via first class mail, postage prepaid, to community service providers by 5:00 p.m. on Friday, August 30, 1996, for subsequent distribution to class members served by such community service providers.

A hearing on the proposed settlement is hereby SCHEDULED for 2:00 p.m. on Friday, September 27, 1996.

Any class member or family member, guardian, or next friend of a class member who wishes to attend and/or participate in the hearing MUST notify the Court by 5:00 p.m. on Friday, September 20, 1996, by filing with the Clerk of Court a typewritten document no more than one page in length (on 8 ½" by 11" paper) that refers to this case by docket number. Any class member or family member, guardian, or next friend of a class member who wishes to submit any comments in support of or in opposition to the proposed settlement MUST file such comments with the Clerk of Court by 5:00 p.m. on Friday, September 20, 1996, in a typewritten document no more than five pages in length (on 8 ½" by 11" paper in no smaller than a ten point font) that refers to this case by docket number. Any class member or family member, guardian, or next friend of a class member who files such comments MUST also contemporaneously mail copies of such comments to one of the. attorneys for plaintiffs, one of the attorneys for defendants, and one of the attorneys for intervenor. Any party that wishes to file a memorandum of law on the proposed settlement MUST do so by 5:00 p.m. on Friday, September 13, 1996.

SO ORDERED this 15 day of August 1996.

/s/_____
JON P. McCALLA
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

NO. 92-2213 M1/V

PEOPLE FIRST OF TENNESSEE; et. al.,)
Plaintiffs,)
)
v.)
)
ARLINGTON DEVELOPMENTAL CENTER;)
et. al.,)
Defendants.)
_____/

NOTICE OF PROPOSED SETTLEMENT OF CLASS ACTION LAWSUIT

TO: A) ALL PERSONS WHO ON OR AFTER DECEMBER 12, 1989, HAVE RESIDED, OR ARE RESIDING AT THE ARLINGTON DEVELOPMENTAL CENTER:

B) ALL PERSONS HAVE BEEN TRANSFERRED FROM ARLINGTON DEVELOPMENTAL CENTER TO OTHER SETTINGS, SUCH AS INTERMEDIATE CARE FACILITIES OR SKILLED NURSING FACILITIES, BUT REMAIN DEFENDANTS' RESPONSIBILITY;

C) ALL PERSONS AT RISK OF BEING

PLACED AT ARLINGTON DEVELOPMENTAL CENTER;

D) FAMILY MEMBERS, GUARDIANS, AND NEXT FRIENDS OF PERSONS LISTED IN A), B), AND C).

This notice describes a proposed settlement agreement of a lawsuit against the Arlington Developmental Center, its superintendent, the Governor of Tennessee, and officials of six State departments and agencies -- the Department of Mental Health and Mental Retardation, the Department of Health, the Medicaid Bureau, and the Department of Human Services including Social Services and Rehabilitation Services. This notice tells you what the lawsuit is about, how to get more information, and how to object to the proposed settlement agreement if you think it is not fair.

The Lawsuit

This class action lawsuit was filed in December 1991 by five residents of the Arlington Developmental Center on behalf of all Center residents, and by People First of Tennessee, a self-advocacy group for persons with disabilities. They wanted to prevent further abuse and neglect in the institution, receive better services for the residents, and secure their legal and constitutional rights, including the fight to freely associate with persons of their choice as guaranteed under the First Amendment of the United States Constitution.

In September 1995 the Court certified the class, defining it as: all persons who after December 12, 1989, have resided or are residing at the Arlington Developmental

Center, all persons who have been transferred to other facilities but who remain the defendants' responsibility and all persons at risk of being placed in the Center. Also, in 1995, the Court addressed the issue of care, services, abuse and neglect by entering a remedial Order in United State v. State of Tennessee, Case No. 92-2062-M1-A, as a final order in this case. Thus, the only remaining issue is the First Amendment rights of the residents. In order to avoid costly litigation on that issue, the parties reached an agreement which would secure the rights of the class members to exercise their freedom to associate and assemble with others of their choice.

The Proposed Settlement

1. The plaintiffs and defendants acknowledge that past violations of the residents' First Amendment rights did occur. Plaintiff/residents were prevented from communicating, associating and assembling with persons of their choice.

2. According to the proposed settlement, the Defendants will protect the rights of the Plaintiff/residents by:

(a) developing a policy to enable residents to communicate, associate, and. assemble with others of their choice both publicly and privately;

(b) telling the staff of the Arlington Developmental Center and agencies who work with the Center about the policy so that the staff will not discourage residents from exercising their fight to freely communicate, associate and assemble with others of their choice;

(c) establishing a process to discipline staff members who violate the right of residents to freely communicate, associate and assemble with others; and

(d) allowing advocates, religious organizations, and community organizations reasonable opportunity to communicate with residents and allowing residents the opportunity to participate in community activities.

How the Settlement Affects Your Rights

The settlement is a complete settlement of all class members' claims regarding the Defendants' interference with Plaintiff/residents' First Amendment rights to freely communicate, associate and assemble with persons of their choice.

How to Comment on the Proposed Settlement

If you do not want to object to this proposed settlement, then it is not necessary for you to take any action. If, however, you want to comment on the proposed settlement or object to it as not being far, reasonable, or adequate, then you or your attorney on your behalf may file no more than five (5) pages of typewritten objections on 8 ½" by 11" paper, in no smaller than a ten (10) point font, by 5:00 p.m. on Friday, September 20, 1996. Comments and objections must refer to this case by docket number and be submitted to the Court at this address:

Office of the Clerk
United States District Court
for the Western District of Tennessee

167 N. Main Street
Room 242
Memphis, Tennessee 38103

If you file comments or objections, then, at the same time, you must also send copies of the filed comments or objections to one of the attorneys for the plaintiffs, one of the attorneys for the defendants, and one of the attorneys for the intervenor. The attorneys' names and addresses are set out below.

How to Obtain More Information

You can get a complete copy of the proposed settlement by writing to plaintiffs' attorneys, at one of the addresses listed below. You may also examine the court papers filed in this case, which can be viewed at the Office of the Clerk for the United States District Court, at the above address by asking to see the file in People First of Tennessee v. The Arlington Developmental Center, Case No. 92-2213 MI/V.

If you have any questions or would like more information about this notice, you may contact your own lawyer or the lawyers for the plaintiffs.

Hearing

A hearing on the proposed settlement will be held at 2:00 p.m. on Friday, September 27, 1996, in Courtroom 4 on the 9th Floor of the Federal Building, Memphis, Tennessee. Any class member or family member, guardian, or next friend of a class member who wishes to attend and/or participate in the hearing must notify the Court by 5:00 p.m. on Friday,

September 20, 1996, by filing with the Clerk of Court at the above address a typewritten document no more than one page in length (on 8 ½" by 11" paper) that refers to this case by docket number.

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APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 92-2213 M1/V

FILED
March 21, 1996

CERTIFIED TRUE COPY
ROBERT R. DI TROLIO
U.S. DISTRICT COURT
WESTERN DISTRICT OF TENNESSEE
/s/_____
BY: DEPUTY CLERK

PEOPLE FIRST OF TENNESSEE; et. al.,)
Plaintiffs,)
)
v.)
)
ARLINGTON DEVELOPMENTAL CENTER)
et. al.,)
Defendants.)
_____/

ORDER

On June 9, 1995, intervenor Parent-Guardian

Association of Arlington Developmental Center filed a motion for leave to file a complaint and change intervenor's status, Intervenor seeks leave "to modify its status to independent" and file a complaint against defendants. Intervenor's proposed complaint states that it is "asserting a claim that those ADC residents who will be moved from ADC to community settings may suffer injury and deprivation of their rights in the new community settings," and request that the Court: 1) Retain jurisdiction of the action as long as necessary to assure that former ADC residents who are moved into community living arrangements are protected from harm," 2) "Issue such preliminary and permanent injunction orders as may be necessary to protect ADC residents (past - present - future) from harm, wherever they should reside, and from violation of their constitutional rights," and 3) "Assure that all community living arrangements for former ADC residents comply with constitutional and all applicable statutory standards." Plaintiffs filed a response on July 12, 1995, and defendants filed a response on July 14, 1995.

There is no such thing as an "independent" intervenor. Therefore, intervenor's motion to change status is hereby DENIED.

Intervenor's motion also seeks leave to file a cross-claim against defendants. The facts of this case indicate that leave should not be granted. The Parent-Guardian Association of Arlington Developmental Center was permitted to intervene in the instant case by order of January 26, 1993. Thereafter, the intervenor filed an answer to plaintiffs' complaint and did not attempt to file a cross-claim against defendants until June 9, 1993. Thus, the current attempt is untimely. Furthermore, the relief that intervenor seeks in its proposed cross-claim is

no longer available in this case and can be addressed only in United State, v. Tennessee, No. 92-2062 MI/A (W.D. Tenn.) (McCalla, J.). The order entered in the instant case on September 27, 1995, leaves only plaintiff's claims for violation of the First Amendment as incorporated by the Fourteenth Amendment. The substantive due process and statutory rights of the residents at Arlington Developmental Center are being dealt with exclusively in United States v. Tennessee -- in which all the parties to the instant case are also parties. Thus, allowing intervenor to file its proposed cross-claim would run contrary to the Court's efforts in previous orders in the two cases to avoid duplication of issues and potentially inconsistent results. Accordingly, intervenor's motion to file a complaint is hereby DENIED.

SO ORDERED this 21 day of March 1996.

/s/_____
JON P. McCALLA
UNITED STATES DISTRICT JUDGE

APPENDIX H

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 92-2213 M1/V

FILED
September 26, 1995
ROBERT R. DI TROLIO
CLERK, U.S. DIST. CT.
W.D. OF TN, MEMPHIS

ORDER GRANTING CLASS CERTIFICATION

Before the Court is plaintiffs' motion for class certification, renewed on June 12, 1995.[1] For those reasons

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[1] On February 11, 1992, the plaintiffs moved for class certification. The Parent-Guardian Association of the Arlington Developmental Center (PGA) filed a motion for leave to intervene for the purpose of opposing class certification, which leave was granted. A brief evidentiary hearing was held on the Motion for class certification on April 28, 1993, after which the Court allowed the parties to supplement the record until July 1, 1993.

U.S.A. v. State of Tennessee, Civil Action No. 92-2062

On January 21, 1992, the United States of America filed suit against the State of Tennessee and named defendants, including the Superintendent of Arlington Developmental Center, pursuant to the

Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, *et seq*. Trial began in that case, United States of America v. State of Tennessee, et al., No. 92-2062 MI/A, on August 30, 1993 (while the motion for class certification in the present case was pending), and the Court issued a comprehensive opinion in open court on November 22, 1993, followed by written Supplemental Findings of Fact on February 17, 1994. The Court found pervasive violations of Arlington residents' rights under the Fourteenth Amendment in almost every aspect of care and services.

In its ruling on November 22, 1993, the Court issued a preliminary injunction to deal with the immediate threat to human life at Arlington. As to permanent injunctive relief, the Court afforded the State of Tennessee an opportunity to comment upon the proposed injunctive order submitted by the United States and directed the Commissioner of the Tennessee Department of Mental Health/Mental Retardation to submit a plan to remedy the violations of constitutional rights and educational opportunities.

Upon motion by the United States, filed February 9, 1994, and by Order docketed April 5, 1994, the Court appointed Dr. Linda O'Neall, an expert with extensive experience in mental retardation, program evaluation, and systemic reform and restructuring of mental retardation, services, to serve as Expert Facilitator to assist the parties in U.S.A. v. State of Tennessee, et al., to develop an acceptable plan for remedying the conditions at Arlington, or, if no agreement could be reached, to develop a remedial plan for consideration by the Court. In August, 1994, the United States and the State of Tennessee reached agreement on the terms of a Remedial Order to correct the violations of Arlington residents' constitutional rights. The agreement was entered as a stipulated Remedial Order, and filed on September 2, 1994. The order provides for extensive improvements in care and services at Arlington and obligates the State of Tennessee to reduce the population of Arlington to no more than 200 persons, subject to the state's receiving approval from the Federal Health Care Financing

stated below, the motion is GRANTED.[2]

Statement of the Case

This case was filed on December 12, 1991, by People First of Tennessee, a statewide advocacy organization governed by people with disabilities, on behalf of its

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Administration to use federal funds for community placement of Arlington residents.

The Instant Case: People First, et al. v. Arlington Developmental Center, et al.

In the instant case, in February 1994, plaintiffs filed a Motion for Partial Summary Judgment asking the Court to enter its findings on liability as findings in this case. A hearing was held on this motion on April 29, 1994. The Court did not decide plaintiffs' outstanding motions for class certification, partial summary judgment, or other motions. Rather, on September 30, 1994, the Court entered an Order Staying Proceedings and denying all outstanding motions without prejudice. The Court instructed the parties to review the Remedial Order and advise the Court how they wished to proceed in this case. At a status conference on March 31, 1995, the plaintiffs informed the Court that they wished to refile the motions and proceed to trial.

[2] The motion for class certification was filed on June 12, 1995, along with a motion to enter the court's findings and order on liability in U.S.A. v. State of Tenn., et al., as findings and orders in this case, a motion for consolidation, and a motion for further relief. These motions will be addressed in a separate order(s).

members, and by five residents of Arlington Developmental Center ("Arlington") to redress unlawful conditions at Arlington, on behalf of themselves and all others similarly situated. Two other individual residents of Arlington were added as named plaintiffs in subsequent motions for leave to amend the complaint. Plaintiffs asserted that defendants denied them minimally adequate living arrangements, habilitation and services at Arlington, in violation of their rights under the First. and Fourteenth Amendments, and certain federal statutes.

The case was filed in the Middle District of Tennessee and subsequently transferred to this Court on the defendants' motion for change of venue. Defendants also filed a motion to dismiss the complaint which was denied as to plaintiffs' Due Process and First Amendment claims.[3] More recently, defendants have filed a motion to dismiss the complaint.

With regard to the motion for class certification, plaintiffs have proposed the following class definition:

> All persons who on or after December 12, 1989, have resided, or are residing or will reside at the Arlington Developmental Center; all persons who have been transferred to Arlington from other settings such as

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[3] The court dismissed plaintiffs' claims under Title XIX of the Social Security Act, Sections 100 and 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, certain First Amendment claims set out in Count IV(b), (d), and (e) of plaintiffs' Amended Complaint, and claims under the Equal Protection Clause. (See Order on Motion to Dismiss, Dec. 22, 1992.)

> intermediate care facilities or skilled nursing facilities but remain defendants' responsibility; and all persons at risk of being placed at Arlington Developmental Center.[4]

Defendants contend, inter alia, that the proposed class definition is too expansive in that it includes former residents and those "at risk" of being placed at ADC. Moreover, .they argue that because a number of parents and/or legal guardians oppose their children's or wards' participation in this law suit, there are an insufficient number of residents to meet the numerosity requirement of a class action suit.

> Rule 23(a) of the Federal Rules of Civil Procedure provides:
>
> **Prerequisites to a Class Action**. One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

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[4] Included within the proposed class are three categories: those who *have resided* at Arlington at any time from December 12, 1989 to present; those who *are residing* at Arlington currently; and all persons at risk of being placed at Arlington in the future.

The Court will address each of these prerequisites below.[5]

Numerosity

Rule 23(a) (1) requires that the class of similarly situated individuals be so numerous that joinder of all members would be impracticable. Numerosity, however, is judged on the particular facts and circumstances of this case, and not on the basis of mere numbers, Senter v. General Motors Corporation, 532 F.2d 511, 523 n.24 (6th Cir. 1976), *cert. denied,* 429 U.S. 870 (1976) (citing Cash v. Swifton Land Corp., 434 F.2d 569, 571 (6th Cir. 1970).. Further, plaintiffs need not show the precise number of class members. Evans v. U.S. Pipe and Foundry Company, 696 F.2d 925, 930 (11th Cir. 1983).

Central to the resolution of the issues in this case is the contention by the defendants and intervenor that the majority of the parents and guardians of Arlington residents oppose the goals of this lawsuit and thus there is an insufficient number of residents to form a class for this suit. In support of this contention, the Parent Guardian Association ("PGA") has submitted for the Court's consideration the responses to two

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[5] Commonality and typicality will be discussed even though the Court has already indicated that typicality and commonality have been adequately addressed by plaintiffs, as indicated in a telephonic conference on May 3, 1995, regarding plaintiffs' motion to compel discovery, wherein the Court sustained defendants' objections to plaintiffs' discovery requests designed to establish commonality and typicality.

questionnaires previously sent by the PGA to parents, relatives and guardians of Arlington residents in January and April 1992, indicating disagreement with this suit; and has provided the Court with declarations from parents and guardians stating their opposition to plaintiffs' claims for class certification as well as to the request of People First of Tennessee to serve as a class representative.

Although these submittals from the parents and/or guardians do indicate that a number of guardians and conservators object to their wards' participation in the lawsuit for those reasons discussed infra, these objections do not defeat the numerosity requirement of class certification.

At present, the population of Arlington Developmental Center is approximately 385 persons. During the time of the first class certification hearing and at the time of trial in United States of America v. State of Tennessee, et al., Civil Action No. 922062, the population was approximately 423 persons, thirty of them minors. The attrition is because some Arlington residents have died during the last two years, and some have left the institution for other settings.

All but approximately 150 of the residents have guardians, conservators or parents who hold various rights and powers of the resident. The guardianship orders for many residents are not uniform. Some have limited guardians and others have plenary guardians.

Examples of limited guardianship orders would be those original probate court orders appointing limited guardians for plaintiffs Watson and Runions, dated April 8, 1986 and November 16, 1987 respectively. Appendix A.

These give the limited guardians the responsibility to consent or make decisions relative to medical and mental examinations, including administration of psychotropic medication; participation in studies supervised by qualified individuals; and participation in activities which are reasonable and necessary for the habilitation of the resident. The limited guardianship order for plaintiff Wilson is identical to those of Watson and Runions, except that it does not contain a provision for consent for participation in studies. Appendix A, p. 6-8.

Before this lawsuit was filed, guardianship orders typically assigned the same powers and duties to the limited guardian .as were assigned to the guardians of Runions and Watson.[6] See

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[6] On March 16, 1992, Mona Reeves-Winfrey, Superintendent of ADC petitioned the Probate Court of Shelby County to substitute Comcare, Inc. for Guardianship and Trust Corporation (GTC) as guardian for Runions and Watson. Comcare, Inc. has a contract with the State of Tennessee and ADC "to provide guardianship services to Arlington residents who require guardians but who have no family members available to act as guardian." Order of March 16, 1992, In re: Herman Walter Runions, Probate Ct. No. 8-5506 (Appendix B, p. 1). In addition to substituting Comcare for GTC, the power "to protect the respondent's personal well-being and legal interests" was also added to the orders substituting guardianship. Appendix B, p. 2. When this lawsuit was filed, GTC expressed no position on Runions' and Watson's participation in this suit. (But see Declaration of Comcare, Inc. at 4, filed July 14, 1995.)

As of April 28, 1993, 220 adult residents at Arlington had court-appointed guardians or conservators; 176 adult residents at

Appendices C & D. That language with relatively minor Variations is contained in the great majority of Guardianship Orders for ADC residents. See Appendixes C & D.

Arlington did not have court-appointed guardians or conservators; and 30 Arlington residents were minors. Affidavit of Dianna Taylor (filed May 12, 1993). Of the 220 adult residents at Arlington who had court-appointed guardians or conservators, approximately (some documents were incomplete) 178 had individuals appointed as guardians or conservators, and 42 had a contract corporate guardian or conservator appointed (either Comcare, Inc. or Guardianship and Trust Corporation of Tennessee). (2-Volume submission by State of Tennessee Relating to ADC Guardianship Orders, filed under seal May 12, 1993.)

On July 24, 1995, updated lists, reflecting changes in the 'resident population since the May 12, 1993 submittal, and copies of additional guardianship orders Were filed. (Exhibit 30, Hearing July 24, 1995.) Exhibit 30 does not contain copies of all orders to which reference is made in the exhibit. (See Exhibit 30, Hearing, July 24, 1995.) At least one (1) pre-1993 Order Appointing Limited Guardian was included in the list and exhibit (Exhibit 30 was to contain only post April 28, 1993 orders). (See Exhibit 30, In the Matter of Annie B. /Hardeman County Chancery No. 8393 (Dec. 20, 1989).) Twenty (20) conservatorship or guardianship orders are contained in Exhibit 30 (Hearing, July 24, 1995).

One hundred thirty-seven (137) declarations have been filed by intervenor in opposition to class certification. (See Intervenors' Notice of Filing Declarations (104 declarations), filed June 9, 1995; Intervenor's Notice of Filing Declarations (second submission) (29 declarations) filed July 13, 1995; Intervenor's Notice of Filing Declarations (third submission) (4 declarations) filed July 21, 1995.)

After the lawsuit was filed, the format changed and an additional power -- "[t]o protect [the resident's] personal well-being and legal interests" -- was added. Appendix B. Although plaintiffs seek a finding that those guardianship orders which add the power "to protect the person's well-being and legal interests" are an obvious effort by defendants to prevent ADC residents from participating in this suit without the guardian's permission, the Court need not reach this point to make a ruling on the motion for class certification.[7]

Two of the individual named plaintiffs, Carl Beard and Stevelyn Tucker, have limited or natural guardians who have consented to their participation as plaintiffs in this case. Beard brings this action by a next friend with the consent of his limited guardian. Tucker brings this action by her parents and natural guardians. A third plaintiff, Keith Collins, is an adult without a guardian. He brings this action by his mother as his next friend.

It is clear from the applicable Tennessee guardianship statutory provisions and the guardianship orders entered that the guardians of most Arlington residents have only limited powers. A new Tennessee conservatorship statute became effective on January 1, 1993, T.C.A. § 34 chs. 11-13; most Arlington residents' guardians were appointed under the previous statute, T.C.A. § 34-1-101, et seq. Under both statutes, all powers that have not specifically been removed

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[7] This evidence may have some bearing on the issue of whether defendants violated plaintiffs' First Amendment rights. The Court, however, is not ruling on that question at this time.

from the ward and vested in the guardian are retained and may be exercised by the ward. The current law provides that

> If the court determines a conservator is needed, the court shall enter an order which shall enter an order which shall
>
> * * *
>
> (2) Enumerate the powers removed from the respondent and vested in the conservator. To the extent not specifically removed, the respondent retains and shall exercise all powers of a person who has not been found to be a disabled person.

T.C.A. §34-13-107.[8]

None of the limited guardianship and conservatorship orders of Arlington residents contain provisions purporting to deprive wards of the right to associate with others, to confer with counsel of their choice, or to participate in litigation through a next friend or class representative. Thus, Arlington residents, with limited guardianship and conservatorship orders retain the right to do anything not specifically deprived

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[8] Similarly, the pre-1993 statute provided:

> Deprivation of respondent's rights -- The court may deprive the respondent of the right to vote, dispose of property, execute instruments, make purchases, enter into contractual relationships, hold a valid Tennessee driver's license, give consent to medical and mental examinations and treatment, or do such other act of legal significance the court deems necessary or advisable.

T.C.A. 34-4-111, *repealed by* Act of 1992, ch. 794, § 50.

of them by the limited guardianship orders.[9]

Further, it is settled law in Tennessee that the rights of minors and other persons under legal disability may not be waived by a natural or legal guardian. "The general rule is that a guardian may not waive the rights of an infant or an incompetent." Childress v. Madison County, 777 S.W.2d. 1, 6 (Tenn. Ct. App., 1989) (citing 39 Am. Jur. 2d *Guardian & Ward* § 102 (1968); 42 Am. Jur. 2d *Infants* § 152 (1969).

Indeed, legal authority supports the proposition that minors and other persons under a legal disability retain the rights of other citizens and that parents and guardians lack the power to waive the fundamental rights of their children and wards. Thus, a minor or ward has standing to sue to enjoin violations of his or her constitutional rights despite the parent's or guardian's consent to the practices or conditions being challenged. See Milonas v. Williams, 691 F.2d 931, 943 (10th Cir. 1982), *cert. denied,* 460 U.S. 1069 (1983) (parent cannot authorize the state to limit a child's liberty without showing good cause); see also Doe by Doe v. Austin,

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[9] It is also clear that under Tennessee law that, except as narrowly limited by orders of guardianship, Arlington residents retain their other basic civil rights and liberties. For example, T.C.A. 33-3-101 provides that, "[n]o person shall be deprived of his [or her] liberty on the grounds that he [or she] is, or is supposed to be, mentally ill, mentally retarded, or in need of mental treatment, except in accordance with the provisions of this title." At Part II of Title 33 Tennessee adopted, as a matter of public policy, a declaration of special rights of the mentally retarded which at Article I provides that a "mentally retarded person has the same basic rights as other citizens of the same country and same age." T.C.A. 33-5-201.

848 F.2d 1386, 1392 (6th Cir.), *cert. denied,* 488 U.S. 967 (1988) (the commitment of mentally retarded adults upon application by a parent or guardian is to be considered involuntary); Thomas S. by Brooks v. Morrow, 601 F.Supp. 1055 (W.D.N.C. 1984), aff'd, 781 F.2d 367 (4th Cir. 1986), *cert. denied sub. nom.* Kirk v. Thomas S. by Brooks, 476 U.S. 1124 (1986) (young man with retardation whose court-appointed guardian had consented to his admission to a state institution had standing to sue the Secretary of the North Carolina Department of Human Resources and his guardian for violating his right to minimally adequate habilitation and unnecessarily restraining his liberty).

As for the Arlington residents whose guardians have the authority "to protect their well-being and legal interest," even if this clause is interpreted to authorize the guardian to bring civil litigation on behalf of the ward, such authority cannot be exclusive. Bonnie S. v. Altman, civ. No. 87-3709; slip. op. at 5 (D.N.J. April 19, 1988) (quoting S. BRAKEL, ET AL., THE MENTALLY DISABLED AND THE LAW 437 (3d ed. 1985) ("[m]odern authorities generally regard the requirement that a guardian sue or be sued for the incompetent person as a protection of the interests of the incompetent person rather than as a limitation on 'his or her capacity to institute suit" (emphasis added by the court)). (Decision is attached to Plaintiffs' Proposed Findings of Fact and Conclusions of Law dated July 4, 1993, as Appendix C).

To hold that a person confined to an institution must obtain the consent of his or her appointed guardian to sue for violations of constitutional rights would render those rights meaningless. Altman at 1. In a lawsuit in which plaintiffs challenge conditions to which their guardians have acceded

and, in fact, defend, "wards cannot be forbidden from suing without their guardians' consent. That consent, by definition, is unlikely to be forthcoming." Id. at 5 (citations omitted).

Given the complexity of the housing, habititation and service issues experienced by members of the proposed class, given the application of a common legal standard of review to all putative class members, plaintiffs satisfy the requirement of numerosity under Rule 23(a) (1) in that joinder of all members would be impracticable.

Commonality and Typicality

The second and third requirements of Rule 23(a) are that there be questions of law and fact common to the class and that the claims of the named plaintiffs be typical of those in the class. Since "the commonality and typicality requirements of Rule 23(a) tend to merge ...," General Telephone Co. v. Falcon, 457 U.S. 147, 157 n.13 (1982), these will be discussed together.

Rule 23(a) (2) requires that there be "questions of law and fact common to the class." Similarly, the requirement of Rule 23(a) (3) requires that for typicality to exist there must be a common element of fact or law. Senter, 532 F.2d at 523. Plaintiffs' claims are typical of those of the class as long as "the claims or defenses of the class and the class representatives arise from the same event or pattern or practice and are based on the same legal theory." Kornberg v. Carnival Cruise Lines, Inc., 741 F.2d 1332, 1337 (11th Cir. 1984), *cert. denied* 470 U.S. 1004 (1985); see also Penn v. San Juan Hospital, Inc., 528 F.2d 1181, 1189 (10th Cir.

1975).

The defendants apparently do not challenge the 'commonality of the proposed class. However, the intervenor contends that the commonality requirement is not met because of the diverse circumstances and unique characteristics of each Arlington resident. Since commonality refers to the defendants' conduct and is not defeated by the presence of individual differences among class members, intervenor's argument is without merit. See Adamson v. Bowen, 855 F.2d 668, 676 (10th Cir.- 1988); Appleyard v. Wallace, 754 F.2d 955, 958 (11th Cir. 1985); and see Baby Neal v. Casey, 43 F.3d 48, 56-57 (3d Cir. 1994) (commonality requirement can be met even though class members have individual circumstances, relying on Califano v. Yamasaki, 442.U.S. 682, 99 S.Ct. 2545, 61 L. Ed. 2d 176 (1979).)

While each individual class member in the instant case, requires individualized services, class members as a whole need similar types of habilitation and services, such as adequate physical therapy, proper feeding techniques, habilitation plans and behavioral programming. The common factual inquiry with respect to all class members is whether defendants are providing constitutionally adequate habilitation as well as whether defendants are prohibiting residents from associating with certain individuals in. violation of their First Amendment rights. Furthermore, based on the record before the Court, the claims of the proposed plaintiff class arises from the same patterns and practices and are based on the same legal theory.

Adequacy of Representation

Rule 23(a) (4) requires the representative parties to be able to fairly and adequately protect the interests of the class as a whole. This prerequisite contains two requirements: that the named plaintiff themselves have no interests antagonistic to those of the rest of the class, and that plaintiffs' counsel be qualified, experienced and generally able to conduct the proposed litigation. See Griffin v. Carlin, 755 F.2d 1516, 1533 (11th cir. 1985) (citing Johnson v. Georgia Highway Express, Inc., 417 F.2d 122, 1125 (5th Cir. 1969)).

As discussed above, the central issue with regard to class certification appears to be whether the lack of consent by parents and guardians for the participation of their sons, daughters and wards in the litigation, renders plaintiffs inadequate representatives of the class. This issue arises from the fact that the great majority of Arlington residents cannot express a choice regarding whether to participate in this lawsuit or a choice regarding the relief that should be entered. This, for a substantial number of the residents, is so because of their particular disabilities along with lack of experience, training and/or assistance in communicating.

The defendants' and intervenor's object to People First as class representatives based principally upon their perception of the "remedial objective" of People First of Tennessee which they characterize as institutional closure for its own sake.[10] The defendants and intervenor do not claim

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[10] People First has standing to bring this action on behalf of its 'members who are members of the proposed class, as well as to protect its own interests as an organization, which are affected by defendants'-alleged refusal to allow People First to communicate with its members and to allow members to attend People First

that the individual named plaintiffs have the same remedial objective(s) as People First and further do not appear to object to the participation of plaintiffs Carl Beard, Keith Collins and Stevelyn Tucker in this lawsuit through their next friends and parents. Thus, defendants and intervenor appear to concede that at least three individual plaintiffs in this action are proper class representatives under Rule 23(a) (4).

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meetings, see Simon v. Eastern Kentucky Welfare Rights' Organization, 426 U.S. 26 (1976) (to establish standing as representative organization, proposed representative must show that members have been injured in fact and that members could have brought suit in their own right); also see Warth v. Seldin, 422 U.S. 490 (1975) . At least nine members of the proposed class, including individual plaintiffs Sandra Howard and Clarence Wilson, are members of People First of Tennessee who have formal membership applications on file with the organization. At least nine additional members of the proposed class have attended People First meetings.

The testimony at the hearing showed that People First has been interested in problems at Arlington since March 1991, when the Department of Justice issued its Letter of Finding to Governor McWherter. After the Letter of Finding was issued, People First convened a special board meeting to discuss the findings. The 'officers of People First also met with the Commissioner of Mental Health/Mental Retardation and left the meeting convinced that the state would not resolve the problems voluntarily.

At the March 1991 special People First board meeting, after discussion of the findings, a motion was made to ask attorneys to come to the next regular board meeting, in June 1991, to discuss litigation.

The defendants and intervenor, however, contend that plaintiffs cannot represent the majority of Arlington residents, and that four of the seven named plaintiffs (Sandra Howard, Herman Runions, Harvey Watson, and Clarence Wilson) are precluded from serving as class representatives, because they have limited guardians who have not consented to their participation as plaintiffs in this action.

As discussed more fully above, the parents and guardians lack the authority to waive the fundamental rights of their children and wards; moreover, any authority by the parents or guardians to bring civil litigation on behalf of their ward is not exclusive.

Additionally, a court may not refuse to certify a class merely because some class members may prefer to leave a potential violation of their rights unremedied. Martino v. McDonald's System, Inc., 81 F.R.D. 81, 85 (N.D. Ill. 1979), (citing 3B MOORE'S FEDERAL PRACTICE, ¶ 23.06-2, 23-197 (1978)); Cullen v. New York State Civil Service Commission, 435 F.Supp. 546, 559 (E.D.N.Y. 1977), *appeal dismissed,* 566 F.2d 846 (2d Cir. 1977).

The holding of the Court of Appeals in Halderman v. Pennhurst, 612 F.2d 84, 109-111 (3d Cir. 1979) is squarely on point in this regard. Pennhurst was a class action suit brought by the Pennsylvania Association for Retarded Citizens and named plaintiffs who were residents of the institution or at risk of placement there. The state defendants challenged certification of the class as proposed by plaintiffs, arguing that a "conflict" existed between the plaintiff organization, which supported community placement, and the vast majority of the parents and guardians, who wished the

institution to remain open. The Court of Appeals rejected the defendants' argument and held that the Pennsylvania Association for Retarded citizens, the named plaintiffs and next friends were proper class representatives because they had alleged and proved violations of Pennhurst residents' constitutional rights that affected all of the residents, not simply those who wished a transfer from Pennhurst. Where the issue was the defendants' liability, disagreement over relief had no bearing on class certification:

> At the liability stage, therefore, important questions of law were common to all members of the class. Thus, *regardless of any subsequent disagreement* as to the appropriate relief, we can think of no persuasive reason to have fractionated the class at that early juncture.

612 F.2d at 109 (emphasis added).

Additionally, courts have found individualized decisions at the remedial stage fully compatible with class certification, see Pennhurst, 612 F.2d 84, 110-111 (3d Cir. 1979), rev'd on other grounds, 451 U.S. 1 (1981).

In the instant case, ample protection exists for the interest of any class member who opposes the relief sought by plaintiffs. It is clear that the interest of any class member who desires to maintain the status quo will be adequately represented by the intervenor or, perhaps, by the defendants. Plaintiffs need not show that the whole or a majority of the class considers his [or her] representation adequate." Eisen v. Carlisle & Jacquelin, 391 F.2d 555, 563 (2d Cir. 1968).

In Richard C. v. Snider, 1993 WL 757634 (W.D. Pa.), the court was faced with an objection by an intervenor parent association, similar to that voiced here against People First, to the class representative status of the Pennsylvania Association for Retarded citizens (PARC) and the Pennsylvania Protection & Advocacy Association. The intervenor claimed that the organizations were not proper class representatives because "they follow a philosophy that institutions such as Western Center are unnecessary and obsolete, are never appropriate for the placement of mentally retarded persons and should be closed." Id. at *5. In response, the court found that

> Although opposing intervenors overstate the position of these organizational plaintiffs, it is true that they advocate the community placement and support, where it is appropriate, of persons residing in Western Center and similar institutions. Their position, however, is not antagonistic to the interests of the class members, notwithstanding the disagreement of the opposing intervenors.

Id.

Based on the foregoing, the Court finds that the named plaintiffs, together with People First of Tennessee, are appropriate representatives in this case. In making such a determination, the court is mindful that to the extent that the views or goals of the parents and guardians are in conflict with those of the named plaintiffs and People First of Tennessee, those views or goals appear to be adequately represented by the Parent Guardian Association which has

been allowed to intervene in this action. By allowing intervention by the PGA and by certifying the class, the Court is assuring all affected parties the opportunity to be heard on the merits of plaintiffs' claims.

Competency Of Counsel

There appears to be no dispute as to the competency of plaintiffs' counsel to represent the class. They are experienced in class action litigation, appear to have extensive knowledge of community service systems and extensive experience enforcing the rights of former institutional residents after they move to the 'community. A brief outline of each counsel's experience is set out below.

Jack Derryberry has handled class action litigation in antitrust actions, employment discrimination actions, and actions under the Equal Protection Clause. He has an extensive practice in the educational rights of persons with disabilities, and also has extensively represented persons with disabilities in civil commitment cases. He serves as a Land Commissioner for the United States District Court for the Middle District of Tennessee.

Edward G. ("Woody") Connette graduated from Davidson College in 1974 and from University of North Carolina Law School in 1977. He has been engaged in the practice of law since graduation from law school. Since 1987, Connette has been a partner in Lesesne & Connette, where his primary emphasis is general civil trial work.

He has served as lead counsel or co-counsel in numerous class actions.

Earle J. Schwarz graduated from Brown University in 1975 and received his J.D. from Vanderbilt University in 1980, where he served as Authorities Editor for the Vanderbilt Journal of Transnational Law. He is a diplomate of the Court Practice Institute, a recipient of the Pro Bono Panel for Senior Citizens Service Award in 1984, and member of the Panel of Arbitrators of the American Arbitration Association. Mr. Schwarz is a partner in the Waring Cox law firm in Memphis, Tennessee. He has served as counsel in federal and state class action lawsuits.

Judith Gran and Frank Laski of the Public Interest Law Center of Philadelphia are class counsel for many of institutional residents and former residents who now live in the community. Ms. Gran graduated from Wellesley College, the University of Chicago, and Temple University School of Law, where she served on the Temple Law Quarterly. Mr. Laski graduated from the University of Massachusetts and Harvard University School of Law. He is President of TASH (the Association for Persons with Severe Handicaps), a leading professional organization in the field of services for persons with severe disabilities.

In addition to meeting the requirements of Rule 23(a), the Court concludes that the requirements of Rule 23(b) (2) have also been satisfied.

For the reasons set out above, it is hereby ORDERED that a class of plaintiffs is certified to include: all persons who on or after December 12, 1989, have resided, or are residing at the Arlington Developmental Center; all persons who have been transferred from Arlington Developmental Center to other settings such as intermediate care facilities or skilled

nursing facilities but remain defendants' responsibility; and all persons at risk of being placed at Arlington Developmental Center.

Entered this 26 day of September 1995.

/s/_____
JON PHIPPS McCALLA
UNITED STATES DISTRICT JUDGE

APPENDIX I

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 92-2213 M1/V

FILED
September 27, 1995
ROBERT R. DI TROLIO
CLERK, U.S. DIST. CT.
W.D. OF TN, MEMPHIS

ORDER GRANTING MOTION TO ENTER FINDINGS FROM 92-2062 IN THIS CASE AND GRANTING MOTION TO INTERVENE IN CIVIL ACTION NO. 92-2062

Before the Court is plaintiffs' Motion for Entry of The Court's Findings And Orders on Liability in United States of America V. State of Tennessee, et al., civil Action No. 92-2062, as Findings of Fact in This Case, and Motion to Consolidated, filed June 12, 1995. More specifically, plaintiffs assert that defendants should be prevented from litigating the issue of defendants' liability for violation of plaintiffs' substantive due process rights[1] because that issue

[1] The parties both agree, and the Court has previously noted, that the substantive due process claim in the present matter is identical

has already been decided by the Court in U.S.A. v. State of Tennessee, civil Action No. 92-2062. Plaintiffs are not seeking issue preclusion on their First Amendment claim since that claim was not litigated in Civil Action No. 92-2062; but they argue that for purposes of judicial economy both cases should be consolidated. For those reasons stated below, the Motion to Enter Findings is GRANTED and the Motion for Consolidation will be treated as a Motion to Intervene, which is GRANTED.

The doctrine of issue preclusion, also known as collateral estoppel, is used to prevent unnecessary relitigation of issues that previously have been decided. Generally, issue preclusion is appropriate where an issue in a prior action was raised, litigated, and actually determined and where the estopped party (defendants) had a full and fair opportunity to be heard on this issue in the prior action. See NLRB v. Master Slack Corp., 773 F.2d 77, 81-81 (6th Cir. 1985). The doctrine, in federal cases, is no longer limited by the need for mutuality of the parties. Allen v. McCurry, 449 U.S. 90, 94-95 (1980) (citing Blinder-Tongue Laboratories, Inc. v. University of Illinois Foundation, 402 U.S. 313 (1971)). Thus, a plaintiff who was not a party to a prior federal suit can, under many circumstances, use collateral estoppel "offensively" in a subsequent case against the party who lost in the earlier suit. See Parklane Hosiery Co. v. Shore, 439 U.S. 322 (1979).

The trial in U.S.A. v. State of Tennessee, et al. began

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to the substantive due process claim litigated in U.S.A. v. State of TN.

on August 30, 1993 and ended on October 26, 1993. During the trial the United States presented a total of 17 witnesses, together with a large number of depositions and deposition excerpts. The state of Tennessee began its defense on September 10, 1993, ultimately presenting the live testimony of 20 witnesses plus a large number of depositions. In rebuttal the United States presented the testimony of three witnesses and the video deposition of Dr. Susan Hyman. Over 440 exhibits were introduced at trial and considered by the court. Based on the extensive evidence presented in this case, the Court entered detailed findings of fact, assessing credibility of witnesses, resolving conflicts in testimony, and weighing the sufficiency of evidence. Specifically, in oral findings of November 22, 1993 (Addendum docketed February 18, 1994) and Supplemental Findings of Fact filed February 18, 1994, the Court found that conditions at Arlington did not meet minimally adequate constitutional standards and, therefore, defendants were found to have violated the due process rights of residents at Arlington Developmental Center.

All of the defendants named in U.S.A., v. State of Tennessee, et al., are officials of the State of Tennessee who are sued in their official capacity. Named defendants include Don Sundquist, Governor of the State of Tennessee, Marjorie Nelle Cardwell, Commissioner of the Tennessee Department of Mental Health and Mental Retardation, and Max Jackson, Superintendent of Arlington Developmental Center.

In the matter currently before the Court, all defendants are named in their official capacity as well. As this Court has previously noted, "When a suit is brought against employees of a state or a county or other political subdivision in their official capacity, the governmental entity with whom they are

employed is, for all practical purposes, the actual party in the case." (Addendum to Supp. Find. of Fact at 3.) Thus, both cases share a common defendant, the State of Tennessee.

A review of the record of U.S.A. v. State of Tennessee, et al. reflects that defendants had a full and fair opportunity to litigate the key issue of whether conditions at Arlington met minimally adequate due process standards prescribed by the Constitution. Additionally, allowing defendants a second opportunity to litigate the same issues already decided by the Court in U.S.A. v. State of Tennessee, et a. would be a waste of judicial resources. Furthermore, defendants agree in their motion to dismiss that collateral estoppel or *res judicata* applies to this case, although they argue that application of either doctrine should result in dismissal of the case. See Motion to Dismiss, filed June 12, 1995.[2] Thus, defendants are barred by the doctrine of issue preclusion from again litigating their liability under this substantive due process claim.[3] Accordingly, the Motion for Entry of the Court's Findings is GRANTED.

Since plaintiffs have established that they meet the

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[2] The motion to dismiss will be addressed by the Court in a separate order of the Court.

[3] In so ruling, the Court, upon reviewing the record, notes that nonmutual offensive collateral estoppel is applicable against the State of Tennessee under the facts in this case and thus the limitation of this doctrine by United States v. Mensoza, 464 U.S. 154 (1984), is not applicable. See, e.g., Colorado Springs Production Credit Association v. Farm Credit Administration, 666 F. Supp. 1475 (D.Col. 1987).

conditions for applying the doctrine of issue preclusion, the prior findings of fact, including supplemental findings of fact (Supplemental Findings, docketed February 18, 1994 (docket entry #251); Addendum docketed February 18, 1994 (docket entry #252)), by the Court in civil Action No. 92-2062 ARE HEREBY ENTERED as findings of fact in this case. Furthermore, the Court having previously found that the Remedial Order, docketed September 2, 1994 (docket entry #338), is the appropriate remedy in this matter for violation of the plaintiffs' due process rights, IT IS HEREBY ORDERED that the Remedial Order, docketed September 2, 1995, IS ENTERED as the final Order in this matter as a remedy for defendants' violation of plaintiffs' Fourteenth Amendment rights.

Consolidation

Plaintiffs have additionally moved for consolidation of the present case with Civil Action No. 92-2062 pursuant to Federal Rule of Civil Procedure 42(a) which allows a Court to consolidate cases when pending actions involve a common question of law or fact to avoid unnecessary costs or delay. Upon consideration of the motion in this matter, it appears that consolidation is not applicable. See Frazier v. Garrison I.S.D. et al., 980 F.2d 1514, 1531-32 (5th Cir. 1993).

However, it appears that plaintiffs are actually seeking to intervene in Civil Action No. 92-2062, under Federal Rule of Civil Procedure 24. Based on the record before the Court

and the facts and circumstances in this case,[4] it is the opinion of this Court that the interest of plaintiffs in Civil Action No 92-2213, as well as the intervenors', are not adequately represented in Civil Action No. 92-2062 and that those interests would be adversely affected if plaintiffs and intervenors were not allowed to intervene in the case of U.S.A. v. State of Tennessee.[5] See United States v. Detroit International Bridge Company, 7 F.3d 497 (6th Cir. 1993) (district court's denial of motion to intervene filed approximately 8 month after the settlement agreement was

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[4] Since December 11, 1992 plaintiffs and intervenor in this case have been allowed to attend depositions and receive documents in USA v. State of Tennessee, et al., Civil Action No. 92-2062. Rule 16(b) Scheduling Order (docketed December 11, 1992). Plaintiffs first sought consolidation with Case No. 92-2062 by motion filed February 7, 1994. See also, Order Directing Plaintiffs and Intervenor to Execute Protective Order (filed December 28, 1992) (allowing presence and receipt of discovery materials by People First plaintiffs and intervenor). Intervention in Civil Action No. 92-2062 will not unduly delay or prejudice the adjudication of the rights of the original parties in that case; moreover, the intervening parties' interests (both the People First plaintiffs and the Parent-Guardian Association) are not adequately represented by the existing parties. Thus, intervention in case no. 92-2062 is appropriate under both Rule 24(a) and 24(b). See U.S. v. Oregon, 839 F.2d 635, 638 (9th Cir. 1988) (state mental health facility residents entitled, as a matter of right, to intervene in federal government civil rights action against state).

[5] Since defendants addressed this issue in their Response to the motion to consolidate, the Court has considered the question of prejudice and determines that intervention would best serve the interests of justice.

dated was an abuse of discretion).

Based on the foregoing, the Motion to Enter Findings is GRANTED and the Motion to Consolidate will be treated as a motion to Intervene which is GRANTED.

Because First Amendment association rights remain to be resolved in this case, a Rule 16(b) follow-up scheduling conference has been set at 9:00 a.m. on Thursday, October 19, 1995 in this case to establish final discovery and motion deadlines on those issues and to set trial and pretrial dates. Counsel should be prepared to address all issues set out in the Court's Standing Order on Rule 16(b) conferences.

Intervenors People First, et al. and the Parent-Guardian Association are also hereby given notice of hearings currently set for 9:30 a.m. on Tuesday, October 10, 1995 and 9:00 a.m. on Friday, October 27, 1995 in Civil Action No. 92-2062.

SO ORDERED this 27 day of September 1995.

/s/_____
JON PHIPPS McCALLA
UNITED STATES DISTRICT JUDGE

APPENDIX J

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 92-2213-M1/Bro

FILED
September 29, 1994
W.D. OF TN, MEMPHIS

PEOPLE FIRST OF TENNESSEE et al.,
Plaintiffs,

v.

ARLINGTON DEVELOPMENTAL CENTER, et al.,
Defendants.

ORDER STAYING PROCEEDINGS

Currently there are several pending motions before the court, including but not limited to a motion for class certification, for appointment of next of friends, for partial summary judgment and for consolidation with civil action number 92-2062. This court filed a stipulated Remedial Order in civil action number 92-2062 on September 2, 1994. That Order addresses the agreed remedy for the unconstitutional

conditions found to exist at Arlington Developmental Center.

The motions pending in the instant matter were filed prior to entry of the Remedial Order in civil action no. 92-2062. The germane claim in the above-styled matter (substantive due process) is identical to the claim resolved in civil action no. 92-2062 which resulted in the entry of a Remedial Order. Accordingly, proceedings in the instant matter are stayed until January 15, 1994, and all motions are denied without prejudice. During the interim the parties to this case are instructed to review the stipulated Remedial Order and determine whether they wish to pursue any of the previously filed motions, wish to file different motions or wish to have the case dismissed without prejudice.

SO ORDERED this 29 day of September, 1994.

/s/_____
JON PHIPPS McCALLA
UNITED STATES DISTRICT JUDGE

APPENDIX K

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 92-2213-M1/A

FILED
January 26, 1993
W.D. OF TN, MEMPHIS

PEOPLE FIRST OF TENNESSEE et al.,
Plaintiffs,

v.

ARLINGTON DEVELOPMENTAL CENTER, et al.,
Defendants.

ORDER ON MOTION TO DISMISS

This cause is before the Court on defendants' motion to dismiss the complaint in its entirety for failure to state a claim under Federal Rule of Civil Procedure 12(b) (6).[1] For

[1] The motion to dismiss included an assertion that Plaintiff People First did not have standing to sue as "next friend" under FRCP

the reasons stated below, the motion to dismiss is GRANTED in part and DENIED in part. Claims under Title XIX of the Social Security Act, Sections 100 and 504 of the Rehabilitation Act of 1973, Title II of the American With Disabilities Act of 1990, the Equal Protection Clause, and the First Amendment as set out in Count IV(b), (d), & (e) are DISMISSED. The claims remaining are those under the First Amendment as set out in Count IV(a) and (c) and the Due Process Clause.

Because this case raises important issues and controlling questions of law as to which there is substantial ground for difference of opinion and that an immediate appeal from this order with respect to certain claims may materially advance the ultimate termination of litigation, the following claims are certified for appeal: (1) Title XIX of the Social Security Act; (2) Sections 100 and 504 of the Rehabilitation Act of 1973; and (3) Title II of the Americans With Disabilities Act of 1990.

This action is brought by People First of Tennessee, a state wide advocacy organization governed entirely by people with disabilities, on behalf of its members and by five

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17(c) because four of the five originally named individual plaintiffs had legal guardians who apparently are opposed to the suit. Even if four of the named plaintiffs did not have standing, at least one plaintiff would and, therefore, this Court can appropriately consider the other issues raised in the motion to dismiss. The issue of standing will not be addressed in this opinion, but will be subsequently considered. See Order filed Oct. 1, 1992, allowing plaintiffs additional time to request discovery on the issue of standing, if warranted.

mentally retarded residents of Arlington Developmental Center ("Arlington") to redress allegedly unlawful conditions at Arlington. The plaintiffs assert that they are denied living arrangements (placement in small, individualized, family-scale community residential programs) and services because of the severity of their retardation and physical disabilities and that defendants have failed to meet their federal statutory and regulatory obligations with regard to placing, monitoring and discharging plaintiffs to alternative non-institutional services.

The original complaint raised claims under five (5) statutory and constitutional provisions.[2] By motion filed January 31, 1992, defendants moved to dismiss the complaint in its entirety. On January 30, 1992, the plaintiffs filed an amended complaint which added a sixth count: Title II of the Americans With Disabilities Act of 1990 ("ADA"), which became effective on January 26, 1992. Defendants moved to dismiss the ADA claim by motion filed February 11, 1992. For purposes of judicial economy, the defendants' two motions to dismiss will be treated as a single motion to dismiss all six counts of the Amended Complaint.

The defendants contend, in the context of this case, that neither Title XIX nor its regulations create rights enforceable under 42 U.S.C. § 1983 against the defendants as providers of service and that the defendants have failed to

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[2] These claims were: (1) Title XIX of the Social Security Act; (2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794); (3) the Due Process Clause of the Fourteenth Amendment, U.S. Constitution; (4) the Equal Protection Clause of the Fourteenth Amendment, U.S. Constitution; and (5) the First Amendment to the U.S. Constitution.

allege any deficiency in the state administrative structure sufficient to state a cause of action. They also argue that the plaintiffs' claims are not cognizable under the Rehabilitation Act; that due process rights are not implicated in this case; that only First Amendment claims pertaining to named individuals are actionable; that the plaintiffs have failed to state an Equal Protection claim; and that the Eleventh Amendment is a bar to some of the claims.[3] Each one of these contentions will be dealt with in turn.

Under the standard of review for a motion to dismiss for failure to state a claim under Rule 12(b) (6), the defendant has the burden of demonstrating that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief. Windsor v. The Tennessean, 719 F.2d 155, 158 (6th Cir. 1983), rehearing denied, 726 F.2d 277, cert. denied, 469 U.S. 826 (1984). In reviewing the motion, the court must accept as true all factual allegations in the complaint. Windsor at 1103. All reasonable inferences are resolved in favor of the plaintiff and dismissal is only appropriate if it appears beyond a doubt that the plaintiff can prove no set of facts in support of the claim which would entitle him or her to relief. Conley v. Gibson, 355 U.S. 41, 45-46 (1957); Ang v. Gamble Co., 932 F.2d 540, 541 (6th Cir. 1991).

Eleventh Amendment

Defendants argue that the Eleventh Amendment is a bar to the plaintiffs' claims against defendants Arlington

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[3] The motion to dismiss also raised the issue of standing. See note 1, supra.

Developmental Center, the Tennessee Department of Mental Health and Mental Retardation, the Tennessee Department of Health, and the Tennessee Department of Human Services for relief under Counts I (social Security Act), III (due process clause), IV (First Amendment) and V (equal protection). Courts are limited by the Eleventh Amendment to providing for only "prospective injunctive relief" against state officials sued in their official capacity. Graham v. National Collegiate Athletic Ass'n, 804 F.2d 953, 959 (6th Cir. 1986). Accordingly, the claims against the above-listed agencies pursuant to the Social Security Act, the due process clause, First Amendment and the equal protection clause are dismissed.[4] However, this Court can consider the merits of the plaintiffs' claims against individual defendant state officials sued in their official capacities since, if successful, plaintiffs could be entitled to prospective injunctive relief.

Title XIX of the social Security Act

The plaintiffs assert that Title XIX of the Social Security Act creates judicially enforceable rights against state officials under 42 U.S.C. § 1983. The defendants agree that the plaintiffs may sue under the Social Security Act when the actions of state officials have denied a direct right to payment, See Maine v. Thiboutot, 448 U.S. 1 (1980), but that the plaintiffs cannot sue the defendants for failure to meet any minimum standards of care -- standards of care which the

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[4] Defendants do not contend the Eleventh Amendment is a bar to plaintiffs' claims pursuant to the Rehabilitation Act. Thus, the Court's analysis under the Rehabilitative act is not only applicable to the named individual defendants, but is also applicable to the defendant agencies.

facility must meet in order to retain federal funding under the Act, which are indirect benefits.

When determining whether a federal statute creates implied rights of action,[5] the primary focus is on congressional intent. Cabinet for Human Resources, Com. of Ky v. Northern Kentucky Welfare Rights Ass'n, 954 F.2d 1179, 1181 (6th Cir. 1992). The Supreme Court in Cort v. Ash, 422 U.S. 66 (1975) set out four factors to consider when determining whether a private remedy is implicit in the statute. These factors are as follows:

(1) Is the plaintiff one of the class for whose special benefit the statute was enacted? (2) Did Congress indicate any intent either to create or deny a remedy? (3) Would implying a remedy for the plaintiff be consistent with the underlying purpose of the legislative scheme? and (4) Would the cause of action be one traditionally delegated to state law such that it should be inappropriate to imply a federal remedy? Cabinet for Human Resources at 1181.

The defendants assert that the courts should not second-guess certification decisions, thereby rendering superfluous the entire administrative review and oversight mechanism developed by Congress through the Medicaid program. Such enforcement by the federal courts would interfere with the administrative system which each state has been required to implement.

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[5] The parties agree that Title XIX does not expressly provide for a private right of action.

Defendants arguments are compelling. This Court is not persuaded that Congress in enacting Title XIX of the Social Security Act intended to create a private cause of action for enforcement of the standards of care which a facility must meet in order to retain funding. Accordingly, plaintiffs' claims under Title XIX are dismissed.[6]

Rehabilitation Act of 1973, and Title II of the American With Disabilities Act of 1990

In order to state a claim under § 504 and Title II [7] plaintiffs must prove (1) that they are handicapped within the meaning of the Act (2) that they are "otherwise qualified" for the services sought, (3) that they were excluded from the services sought solely by reason of these handicaps, and (4) that the program in question receives federal financial assistance. Clark v. Cohen, 613 F. Supp. 684, 692 (D.C.Pa. 1985), affirm'd on other grounds, 794, F.2d 79 (3rd Cir.), cert denied, 479 U.S. 962 (1986); See also Doherty v. Southern College of Optometry, 862 F.2d 570 (6th Cir. 1988).

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[6] Although Title XIX does not provide the mechanism for private enforcement of standards of care, the essence of some of these claims is remedied through the due process clause of the Fourteenth Amendment. See substantive due process analysis, infra.

[7] Plaintiffs and defendants agree that the analysis under § 504 and Title II would be the same under the facts and claims asserted by the plaintiffs. Additionally, the parties agree that the Eleventh Amendment is not a bar to claims arising under Title II of the ADA and § 504.

Plaintiffs are claiming, inter alia, that some Arlington residents are being excluded from community services, because of the severity of their retardation or physical disabilities, but that other handicapped persons are receiving such services. However, an action asserting that certain plaintiffs have been the victim of discrimination vis-a-vis other handicapped people must fail because § 504 does not cover discrimination among similarly handicapped persons. Clark at 693; Johnson v. Thompson, No. 90-6107, slip op. at 5 (10th Cir., August 7, 1992). Accordingly, plaintiffs claims under the Rehabilitation Act and Title II of the ADA are dismissed.

Due Process

With respect to the due process clause of the Fourteenth Amendment, the complaint primarily sets out substantive due process issues, although there appears to be at least one allegation which goes toward a procedural due process claim. This Court has already recognized the substantive due process rights of institutionalized individuals. See USA v. State of TN, Docket No. 92-2062.[8] Since the

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[8] Although the vast majority of residents at Arlington were placed there at the request of their parents or guardians, as opposed to a court commitment procedure, it is reasonable to infer from the facts as alleged that there is sufficient state action in the process used to admit residents into the facility to trigger substantive due process rights under the Fourteenth Amendment. See Parham v. J.R., 442 U.S. 584, 600 (1979) ("It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment and that the state's involvement in the commitment decision constitutes state action under the

plaintiff has alleged sufficient facts to support a claim of violations of substantive rights, dismissal is not appropriate. Accordingly, the defendants motion to dismiss the substantive due process claim is denied.

The plaintiffs contend that they have been denied an opportunity to be heard on the appropriateness of their habilitative plans, programs and environment. Under the standard of a motion to dismiss, the Court must take as true the allegations in the complaint. At this point in time, it appears that Arlington residents are entitled to some review or hearing during the course of their stay. See Clark at 697-701. Without further evidence on this point, this Court is reluctant to dismiss this claim. Therefore, the procedural due process claim, if any, will not be dismissed until this court has further information regarding any hearings that may have been conducted during the confinement of some of the plaintiffs. Accordingly, defendants' motion to dismiss the procedural due process claims is denied.

First Amendment

Fourteenth Amendment"). Also, under Tennessee law, once an individual is confined to Arlington the mentally retarded person is under the "exclusive care, custody and control of the commissioner and superintendent." Tenn. Code Ann. § 33-5-103. Once the state has accepted the individual into its custody and control, the state has assumed some responsibility for the safety and well-being of the resident. See DeShaney at 1005. Moreover, the alleged harm is caused by state actors who control every aspect of the resident's daily life, including treatment, care and his or her movement in and out of the institution.

Under Count IV, the plaintiffs aver that their First Amendment rights of freedom of expression and association and religion have been violated by defendants. Although the defendant concede that the plaintiffs may have stated a claim under the First Amendment because of certain alleged incidents not related to any policy at Arlington, subsections (b), (d) and (e) are dismiss because none of the plaintiffs have alleged any injury with respect to these allegations. However, plaintiffs have sufficiently alleged facts to support their claims under Count IV(a) and (c) and, therefore, defendants motion to dismiss those claims is denied.

Equal Protection

The plaintiffs additionally assert equal protection violations. Defendants claim that mental retardation is not a suspect or quasi-suspect class, that institutionalization is a rational choice, and thus there is no equal protection claim. This Court agrees that the equal protection claim should be dismissed.

Mentally retarded persons are not a suspect classification and, therefore, the court only applies rational basis scrutiny. City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985). There is sufficient logical rationale for the defendants' actions to overcome the plaintiffs' challenge. Accordingly, plaintiffs' equal protection claim is dismissed. Moreover, Section 504 codified the equal protection clause with respect to persons with disabilities. Since the § 504 claim is dismissed, plaintiffs' equal protection claim likewise fails.

Based on the foregoing, defendants' motion to dismiss is GRANTED in part and DENIED in part. Claims under

Title XIX of the Social Security Act, Sections 100 and 504 of the Rehabilitation Act of 1973, Title II of the American With Disabilities Act of 1990, the Equal Protection Clause, and the First Amendment as set out in Count IV(b),(d), & (e) are DISMISSED. The claims remaining are those under the First Amendment as set out in Count IV(a) and (c) and the Due Process Clause.

As already noted above, because this case raises important issues and controlling questions of law as to which there is substantial ground for difference of opinion and that an immediate appeal from this order with respect to certain claims may materially advance the ultimate termination of litigation, the following claims are certified for appeal: (1) claims under Title XIX of the Social Security Act; (2) claims under Sections 100 and 504 of the Rehabilitation Act of 1973; and (3) claims under Title II of the Americans With Disabilities Act of 1990.

SO ORDERED this 25 day of January, 1993.

/s/_____
JON PHIPPS McCALLA
DISTRICT COURT JUDGE

APPENDIX L

ADDENDUM[1]

USA V. STATE OF TENNESSEE

Civil Action No. 92-2062

CERTIFIED TRUE COPY
ROBERT R. DI TROLIO
U.S. DISTRICT COURT
WESTERN DISTRICT OF TENNESSEE

BY:/S/_____
DEPUTY CLERK

I'm going to go through some comments in this case and it will take me a little time to do that. I also want to make it clear, and it will be clear from my written comments, that the defendant in this case, of course, is the State of Tennessee. I point that out because, obviously, sometimes it is necessary for me to make comments which seem to be directed at individuals. Now, that is because no institution, whether it is the state or the federal government, can act through anyone other than those people who work for that entity. But it is, of course, the State of Tennessee that has the responsibilities in this case, and it is to the State of Tennessee

[1] The following are the comments made by Judge Jon Phipps McCalla on November 22, 1993. Clerical corrections have been made.

and to the United States that I direct my comments.

I also point out in this case, that the rights of those individuals who are being litigated are the rights of individuals whose condition precludes them often from making their own complaint. Often they are individuals who, while they enjoy all of the constitutional rights of every citizen of this country, are unable, because of physical or mental disability, to articulate their own claim. While that does not give them special rights, it points out the problem that each of us must recognize, and that is that often it is the circumstantial evidence which has great weight in these cases. We are generally unable to hear from those individuals who would in many cases be the ones to articulate the claim.

Ladies and gentlemen, it is important that each of you recognizes that this is a court of law and a nation of laws, and. that the settlement of disputes between people through a lawsuit is a strong and necessary foundation upon which our civilization rests. It is proper, under our system of justice, when there is a dispute between parties regarding the application of the law, that those parties resolve their case in court. It is the responsibility of the federal district courts to hear those claims, and specifically to hear those claims arising under the Constitution and laws of the United States, and to render a prompt decision regarding the application of the law to the facts as established by the record during the trial.

In making that decision, the law requires that the Court not be influenced by sympathy, bias, prejudice or passion. This is a case in which there has been much testimony, much testimony which might be very sympathetic for one side or the other; but, the Court must make its

decision not based on a sympathetic reaction, but on the objective facts as established on the record.

Additionally, the Court must consider all of the applicable law and not a single principle in reaching its conclusion. The Court may not disregard a portion of the law and make its decision only on a single law, but must regard all of the law, and each law, in light of all of the other applicable laws. The United States, in accordance with the authority granted by Congress under the Civil Rights of Institutionalized Persons Act, which is sometimes referred to as CRIPA, is the plaintiff in this case. While the United States appears as a frequent litigant in federal district courts, it is entitled to no special consideration and appears before the Court as any other litigant.

The burden placed on the United States is no different from the burden placed on other litigants before the Court in similar cases. And if the United States fails to satisfy any portion of that burden by the standard placed upon it by the law, it cannot prevail on that claim or claims.

In this case, the State of Tennessee and several individuals named in their official capacity as employees of the State of Tennessee are defendants. When a suit is brought against employees of a state or a county or other political subdivision in their official capacity, the governmental entity with whom they are employed is, for all practical purposes, the actual party in the case. The State of Tennessee, merely because it is a state, is not entitled to special consideration in this case. Just as the United States, the State of Tennessee, as with every other litigant, is entitled to no preferential treatment under the laws in this case.

As I previously noted, the United States has brought this case pursuant to the civil Rights of Institutionalized Persons Act and asserts that the State of Tennessee, in its operation of. the Arlington Developmental Center, has failed to comply with those laws protecting the civil rights of disabled individuals and has failed to provide to those individuals educational opportunities as required under the Individuals with Disabilities Education Act. The United States more specifically claims that the defendants have failed to provide adequate food, medical care, reasonable safety and training, freedom from unreasonable restraints and adequate psychological and psychiatric services as required under the Fourteenth Amendment of the United States Constitution, and has failed to provide Arlington residents under the age of 22 with the educational services required by IDEA.

The State of Tennessee, the governor of the State of Tennessee, the director of the Department of Mental Health and Mental Retardation, and the Superintendent of the Arlington Developmental Center are the defendants in this case. All of the individuals named in this case, as I have indicated, are named in their official capacities.

The defendants contend that their operation of the Arlington Developmental Center has not fallen so far below the standard of acceptable care for individuals with mental retardation as to constitute a violation of those individuals' civil rights. The defendants further contend that the educational opportunities provided to the residents of Arlington Developmental Center below the age of 22 are in compliance with the Individuals with Disabilities Education Act.

I will explain to you somewhat the procedure that the Court goes through in deciding a case of this nature or, for that matter, any case. The Court in this case, and... I refer to the Court, because it sounds funny to say me all the time, but I have to act as the Court in this case. Now, when a person acts as the Court or the judge, you no longer act as an individual. Your individual beliefs or perceptions are not what govern your conduct, but rather the laws of the United States and the Constitution of the United States. The Court also acts in the capacity as a fact-finder. The Court has to decide what are the true facts in this case. So when I say the Court, I think it is best for you to understand that I am not confused about who I am and who the Court is, but it is important for each of you to understand that the Court does not act like me. The Court is, in fact, something that is more than just an individual speaking. The Court, in this case, is the judge of the facts concerning the controversy in this lawsuit.

The trial of this case began on August 30, 1993, with the testimony of Dr. Walter P. Christian, the first witness presented by the United States. sixteen additional witnesses testified in the courtroom, many of whom or some of whom were seen by individual members here, and all of whom were seen by the lawyers. And, a large number of depositions or portions of depositions were placed in the record.

On September 10, 1993, the State of Tennessee presented its first witness, Mona Reeves-Winfrey, the Superintendent of the Arlington Developmental Center. Seven other witnesses testified for the state. The case was then recessed from September 17, 1993, to October 18, 1993, at which time the state resumed its proof with the testimony of Dr. Alexander Horwitz. The state presented an additional 11 witnesses,

including the testimony of Dr. Philip Robert Ziring. The United States then presented three rebuttal witnesses by live testimony, Dr. Walter Christian, Dr. Victoria Therriault, and Dr. Irene McEwen, all of whom had previously testified in the case, and also presented by video deposition the testimony of Dr. Susan Hyman. The parties were allowed to submit post-trial proposed findings of fact and post-trial memoranda; and the United States submitted a proposed order in this case.

It is now for the Court to determine what the true facts are in this case and to apply the law to those facts. Now, in order for a fact-finder to determine what the true facts are, the fact-finder is called upon to weigh the testimony of every witness who has appeared before it or whose testimony has been submitted into evidence and to give the testimony of the witnesses the weight, faith, credit and value to which the Court determines it is entitled. In determining which testimony to believe and, where necessary, which testimony not to believe, the Court considers a number of factors. The factors that the Court has considered in determining the credibility or believability of each witness include the manner and demeanor of the witness while on the witness stand; whether the witness impressed the Court as one who was telling the truth or one who was telling a falsehood; and whether or not the witness was a frank witness. The Court also considered the reasonableness or unreasonableness of the testimony of the witness; the opportunity or lack of opportunity of the witness to know the facts about which he or she testified; the intelligence or lack of intelligence of the witness; the interest of the witness in the result of the lawsuit, if any; the relationship of the witness to any of the parties to the lawsuit, if any; and whether the witness testified inconsistently while on the witness stand or if the witness said

or did something or failed to say or do something at any other time that is inconsistent with what that witness said while testifying.

If there is a conflict in the testimony of the witnesses, it is the Court's duty to reconcile that conflict, if it can be reconciled, because the law presumes that every witness has attempted to and has testified to the truth. But if there is a conflict in the testimony of the witnesses that the Court is not able to reconcile, then the Court has to determine which ones of the witnesses to believe and which ones it cannot believe -- that is which witnesses testified to a falsehood. Of course, immaterial discrepancies do not affect a witness' testimony, but material discrepancies do. It should be noted that the greater weight of the evidence in a case is not determined by the number of witnesses testifying to a particular fact or a particular state of facts, rather it depends on the weight, credit and value of the total evidence on either side of the issue.

As I previously noted, the Court may also consider circumstantial evidence, as well as direct evidence, in deciding a case and, obviously, the law permits the Court to give equal weight to both direct and circumstantial evidence. Of course, it is up to the Court to decide what weight to give any of it.

In this case, particularly for those of you who have participated in this case and for those of you who have attended portions of it, there have been a large number of individuals who are called expert witnesses. You may not, if you are not a lawyer, understand or know that the Rules of Evidence do not normally permit a person to testify as to opinion or conclusions. An exception to this rule exists for

those who testify under the Rules of Evidence as an expert witness.

An expert witness is a person, who by education and experience, has become an expert in some art, science, profession or calling. Expert witnesses are allowed to state their opinions as to those things which are relevant and material and, of course, as to those things to which they profess to be expert and they may give their reasons for that opinion.

In this case, the Court has considered each expert opinion received as evidence in the case and has given each expert's opinion that weight, if any, the Court thinks it deserves. Where an expert opinion is not based on sufficient education and experience, or if the Court concludes that the reasons given in support of the opinion are not supported by the record, or if the Court finds that the opinion is outweighed by other evidence or is unsupported by the facts in the case, the Court may disregard an expert opinion, or at least portions of that opinion.

In this case, there have been three categories of individuals supplying testimony. Additionally, there have been over 440 exhibits. Actually, many of those have not been paper exhibits, but there have been many, many exhibits, some of which are long documents, others of which are videotapes. These exhibits include records from Arlington Developmental Center. They include videotapes of the facility and of practices at the facility. They include photographs of patients and they include charts and graphs containing summary information.

Now, the testimony has been from three basic groups of people. First, current and former employees of Arlington Developmental Center. Second, parents and family members of individuals who are or were residents at Arlington Developmental Center and, third, experts and consultants retained either by the United States or the State of Tennessee in connection with this case or in connection with contracts to provide services to Arlington Developmental Center.

As is often the case, the documents generated at the time of the occurrence of events often provide some of the most reliable information concerning the events in this case. I will talk a little bit more about some of those documents later. However, I have considered all of those documents in reaching my conclusions in this case. Additionally, those individuals who are currently at Arlington, Developmental Center or who have previously worked there are in a particularly good position to provide information regarding the ordinary practices and policies of the institution,

Parents and family members are in a position to provide some information, and their testimony has been appreciated add has been helpful. Of course, the Court must recognize that individuals who have made the choice to place their loved one in any institution have a strong desire for that institution to provide the best possible care. Additionally, and understandably, their view of the institution may be strongly affected by whether they have a continuing interest in the institution as a care provider or whether they no longer have that interest.

The testimony of experts, of course, is affected by the reliability of the information they receive on which they base

their expert testimony. If they receive inaccurate or incomplete information, then the testimony provided by the expert may be of limited or little value. Similarly, if their inquiry is a narrow inquiry as to a specific aspect of the institution, their opinion may have little or no application to other parts of that institution. Finally, if they can be demonstrated to have previously existing biases or prejudices or to have previously committed to a position without examination of the facts at the institution, their testimony may be severely impeached. Before I proceed to tell you my assessment of the evidence, I am going to review with you in some more detail what the United States must prove in order to meet its burden of proof on its claim that the State of Tennessee has violated the Fourteenth Amendment rights of the residents at that institution.

Again, in order for the plaintiff to establish a violation of the Fourteenth Amendment, the plaintiff must show that the defendants committed the acts alleged by the plaintiff, that those facts caused the residents of Arlington Developmental Center to suffer the loss of a federal right, and that, in performing the acts alleged, the defendants' actions were a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base a decision on such a judgment. A mere negligent act by the defendants causing harm does not constitute a violation of the Fourteenth Amendment even though those acts would constitute malpractice. Thus, a mere lack of due care by the state official does not deprive a resident of a constitutional right under the Fourteenth Amendment.

I now also want to review with you more particularly

some of the language from the United States Supreme Court in the case of Youngberg v. Romeo which, I believe, sets out the principles governing the Fourteenth Amendment claim in this case.

In Youngberg, the Supreme Court specifically stated

> When a person is institutionalized and wholly dependent on the state-. . . a duty to provide certain services and care does exist, although even then a state necessarily has considerable discretion in determining the nature and scope of its responsibilities.

The Supreme Court in Youngberg went on to specifically raise the question of what is the proper standard for determining whether a state adequately has protected the rights of the mentally retarded. The Court pointed out that the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made. "...[The mentally retarded] are entitled to more considerate treatment and conditions of confinement better than criminals whose conditions of confinement are designed to punish."

Obviously, the Supreme Court points that out because we have always recognized in the United States, or at least for a number of years, that individuals who are incarcerated involuntarily for the purpose of punishment give up many rights. So the court points out in Youngberg that individuals in institutions of this nature have rights and that those rights are different from the rights of those people who are

involuntarily incarcerated for purposes of punishment.

In Youngberg, the Supreme Court also observed

> that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized.

The Court noted that "courts should not 'second-guess the expert administrators on matters on which they are better informed.'" The Court indicated that

> for those reasons, the decision, if made by a professional, is presumed valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.

Youngberg reminds us that the state has "a duty to provide adequate food, shelter, clothing and medical care. These are the essentials of the care that the state must provide." The state also has the unquestioned duty to provide reasonable safety for all residents and personnel within the institution. "[Residents enjoy] constitutionally protected interests in the conditions of reasonable care and safety, reasonable non-restrictive confinement conditions, and such

training as may be required by these interests." It is these principles that govern the determination made by the Court today.

In reviewing the evidence in this case, there is much testimony and documentation which appears to be reconcilable. As a general proposition, it appears that even the defense experts do not seriously question that conditions at Arlington Developmental Center in 1990 and 1991 failed to comply with minimal requirements established under the Fourteenth Amendment for individuals with mental retardation. In 1990 and 1991, key positions at the institutions were unfilled; psychiatric and psychological services were virtually nonexistent; outside consultants were rarely, if ever, used; and, staff lacked the training or direction to properly feed, train, monitor and care for this population.

Even at the time of his testimony on September 14, 1993, Dr. John Scott Bailey, a Fellow of the American Psychological Association and a professor at Florida State University and a consultant for the State of Tennessee stated that he is only now beginning to see people who are "starting to be sensitive" to the needs of residents at Arlington Developmental Center. Dr. Bailey appeared to concede that data collection at Arlington Developmental Center is "really not quite good enough to develop behavior development plans." Dr. Bailey described the work of one of his colleagues, Dr. Riordan, in one of the resident cottages at Arlington Developmental Center, indicating that in the Spruce Unit "they are doing much better" and that in other areas they are "not as good."

Dr. Bailey described the psychology staff as "in

transition" and acknowledged that since December 1992, "some of them have quit and some have been added." He also stated that "none of the masters level psychologists have a background in behavior analysis." He also said "we have asked a lot of people to change the way they are doing things - they are getting more interested, more involved, morale has improved a little bit on the two units we have been most involved in." Dr. Bailey acknowledged that he is not a clinical psychologist and confirmed that he did not independently verify any of the data submitted by Arlington Developmental Center for some of his calculations.

I should also note that Dr. Bailey submitted a document entitled Some Common Characteristics of Severely and Profoundly Retarded Persons, marked as Exhibit 308, which, on cross-examination of Dr. Bailey and on explanation by other witnesses, was thoroughly discredited.

Dr. Alexander B. Horwitz, a doctor of psychiatry and a consultant for Arlington Developmental Center, had only, as of the month of his testimony, recently been increased from 16 hours of consultation per month to 44 hours of consultation per month at Arlington Developmental Center. Dr. Horwitz, again, an expert for the defendants, gave testimony contrary to the testimony of the Director of Psychology of Arlington Developmental Center, Dr. Beverly Cox. Dr. Cox had given testimony to the effect that some or many of Arlington residents would prefer to be alone, whereas Dr. Horwitz's testimony was that "sitting alone - not socializing - is a behavioral problem." Dr. Horwitz, of course, is a trained psychiatrist, whereas Dr. Cox has a Ph.D. in education and a masters in guidance. While Dr. Horwitz has been a consultant for Arlington Developmental Center for over one

year, he acknowledged that he has "never performed a data collection check" and that he would "be concerned" if he found that certain patients were "not getting behavioral reinforcement."

Dr. Michael J. Levine, a developmental neuropsychiatrist in. the State of Louisiana and medical director for the Office for Citizens With Development Disabilities of the State of Louisiana, also testified as an expert for the State of Tennessee. Dr. Levine, more bluntly than Dr. Horwitz, stated his candid opinion, as the Court understood, that Dr. Cox, the Director of Psychology at Arlington Developmental Center, "did not have the level of training" required. He went on to state the opinion that "experts from out of state are fun to have.., but you have to 'grow your own' internal expertise." Moreover, in his initial deposition, Dr. Levine stated that "Arlington Developmental Center did not meet common practice in neuropsychiatry" and he stated that a good initial evaluation of five to seven pages is essential, and normal in Louisiana, but that he saw none of that at Arlington Developmental Center. He was careful to say that he did not evaluate the quality and quantity of staffing at Arlington Developmental Center, but noted that he did find things missing in records and found "no particular pattern in charts." He admitted that Arlington Developmental Center "did not have data collection under control." Dr. Levine described going to Arlington Developmental Center's psychiatric program as "like going to Samoa and asking where is your nuclear reactor." He also compared Arlington Developmental Center with the research program at the University of California, Los Angeles,.indicating that it was like comparing a Cadillac factory, that is UCLA, to an ox cart factory, Arlington Developmental Center. He stated that he

did not see training taking place at meal time at the time he gave his deposition, and he also confirmed that he saw very little social skill program development. Dr. Levine criticized the way in which Arlington Developmental's records are oriented, indicating that they are problem oriented records and that they should have been service oriented records.

While the State of Tennessee's experts and consultants were very cautious in their testimony regarding psychological and psychiatric services, the experts presented by the United States were unequivocal in their insistence that the services, processes, procedures, medications and treatments provided in this institution fall so far below any acceptable standard as to constitute a failure to exercise professional judgment in their entirety.

Dr. Walter Christian, a Ph.D. clinical psychologist and president of the May Institute in Chatham, Massachusetts, testified both in the United States initial presentation of proof and in rebuttal. Dr. Christian visited Arlington Developmental Center on October 14 and 15, 1993. You will recall that we had a break in the presentation of the testimony and he visited it again having previously gone several other times.

He visited the Arlington Developmental Center, as I indicated, on October 14 and 15, 1993, to determine whether psychological services had improved since his previous visits to' Arlington. The visit was a surprise visit as authorized by the Court, and Dr. Christian found "that most patients were idle" and he saw "more self-injury than on any previous tour." Because his October visit was a surprise visit, he concluded that the previous visits "were staged for my benefit," in his words.

He testified that conditions in his October visit were worse than the visit in July of 1991, his first visit to the facility. He found that the staff was poorly trained; that there was no evidence that the staff was better trained; that the staff-to-patient ratio remained inadequate; and that the number of psychologists remained totally inadequate. He found that the Daniel Boone cottage, which had been the subject of work by
Dr. Bailey, whom I have previously mentioned, was, in October of 1993, in "worse shape than many base line units" and he observed that this was after the consultants had essentially finished their work at Daniel Boone. He testified that the problems with self-injury, inability of staff to react to situations, and inadequate or no data collection were, according to Dr. Christian, still in existence during his October visit.

Dr. Christian even described his observations of a resident -- in fact, he described his observations of several residents but he described his observations of Candace T. who had previously been observed self-injuring herself in order to obtain reinforcement with orange juice. During his visit in October, she was found sitting in a line of nonambulatory patients facing a wall. It appeared that no one was observing this group of residents and certainly that no one was interacting with them. Ultimately, after waiting some period of time, he determined that these residents had apparently been placed in line facing the wall so that a staff member could sit in an office at a desk and look out the office door to see the patients or the residents lined up.

Dr. Christian found that the "blue cards," described at some length by Dennis Mozingo in his testimony on behalf of

the United States, were, in Dr. Christian's words, "just a bell and whistle which was not being properly used to. record behavior." Dr. Christian observed, in Daniel Boone 3 at 9:00 a.m. during his visit, that 11 people had still not had breakfast because of the new improved feeding program adopted by Arlington Developmental Center.

In reconciling the testimony of Dr. Christian, Dr. Bailey, Dr. Horwitz, Dr. Cox, Dr. Szymanski and others, there is no credible testimony that conditions have substantially improved from the period of July, 1991, when it is virtually conceded by the State of Tennessee that psychiatric and psychological services were virtually nonexistent. While it is true that some limited progress may have been made in identifying and analyzing the problem, and, in that regard, the State of Tennessee should be commended, the actual delivery of services to the vast majority of Arlington Developmental Center residents who are in need of them, and the development of a system to provide for the delivery, monitoring and sustaining of those services, has yet to occur.

The pattern demonstrated by the experiences of Drs. Bailey, Riordan, Mozingo, and others consulting to provide improved care at Arlington Developmental Center has been repeated in other areas as well. Thus, while improvements have been planned by Dr. William Hinkle in feeding programs and efforts to implement improvements have been undertaken by Carla LyDn Andreas, the lack of any judgment in implementing that. advice has resulted in a failure, thus far, of the institution to meet any minimal standards.

In a surprise visit authorized by the Court on October

1 and 2, 1993, Victoria Therriault observed the same problem as Dr. Christian concerning long delays in residents being allowed to eat. Additionally, while there may be some improvement in the preparation of actual feeding plans, Nurse Therriault testified that those individuals who were actually feeding residents generally had not been trained on any feeding plan at all or had specifically not been trained on the feeding plan for the resident they were feeding.

Apparently, because it was a surprise visit and not a planned visit, Nurse Therriault was also able to consistently observe inadequate staff-to-resident ratios and failure of staff to interact with residents. She found as many as ten people in the Holly Unit who were completely unsupervised, that is, alone. This is significant and was significant to Nurse Therriault because those individuals had been identified as individuals at high risk. As she had observed in her earlier visits in October, she saw food trays which were given to the wrong patient - a particular problem since many patients require specialized diets and the consumption of the wrong or wrongly textured food may result in immediate harm or even death. Nurse Therriault also saw, during her October, 1993 visit, continued improper nursing care in connection with the administration of medication, and the repositioning of a patient by a nurse in which the nurse actually pulled up on a fractured arm, causing the patient to cry out. Once again, Nurse Therriault was able to observe records in which no vital signs had been taken when appropriate and where patients with greater than therapeutic drug levels were experiencing a complication which nursing personnel should have, but did not, identify.

Weighing all of the expert testimony in this case,

including the testimony of individuals who were consultants or employees of Arlington Developmental Center, it is clear that the care actually provided to residents at Arlington Developmental Center falls well below any minimum standard and well below the medical malpractice standard. It further appears, and the Court finds, that the care at Arlington Developmental Center fails to meet the constitutional test which I told you about earlier, as set out by the Supreme Court, in Youngberg v. Romeo.

A similar analysis, when applied to the testimony concerning compliance with the Individuals with Disabilities Education Act, reveals that the requirements of that act are not being satisfied. It is clear that in this area, some progress may be being made and that the consultants in this area have perhaps had the most satisfactory effect.

The evidence from the State of Tennessee itself, however, reflects that the principal within the Arlington Developmental Center has recently almost been terminated and that the best teacher, and the teacher who was shown in the videotape as illustrative of good teaching at Arlington Developmental Center, has now left Arlington Developmental Center.

It is clear from the testimony of the defendants' own expert, Dr. Gene Alvin Vergason, President of Vergason Associates, Inc., that the individual education plans are, in fact, inadequate under the Act and that Arlington Developmental Center does not meet the standard for the use of assessment data. Dr. Vergason observed that it was necessary for him to combine the individual habilitation plan and the individual education plan in order to obtain sufficient

data to create an adequate IEP. Dr. Vergason concedes that the IEP should have all of the education goals contained in that plan. Dr. Vergason testified that the Arlington Developmental Center is doing well in placing students in the least restrictive environment and that he has observed improvements in attitude, institutional technique, materials and activities. His testimony was that Arlington Developmental Center is moving "in the right direction." Dr. Vergason's credibility, however, was placed at issue and in question because his initial opinions were given without the benefit of an adequate review. His conclusions, generally, however, are not irreconcilable with the proof submitted by the United States through Dr. Susan Thibadeaux, the May Center program director. Dr. Thibadeaux pointed out, from her three visits to Arlington Developmental Center, that the Individual Educational Plans, IEP's, are inadequate under IDEA standards. Specifically, the goals and objectives are not sufficiently comprehensive and the system is inadequate to measure progress. In fact, that was very, very clearly demonstrated. Dr. Thibadeaux gave numerous examples from actual students at Arlington Developmental Center in that regard. She also testified that related services are not adequately incorporated into the educational process. For example, the physical therapist interviewed did not even know what an Individual Education Plan was. Yet, with this student population, physical therapy must work closely with education in order to achieve educational objectives since many of those objectives are functional in nature. Reviewing the testimony of Dr. Vergason in conjunction with the testimony of Dr. Thibadeaux, the evidence weighs heavily in favor of a determination that Arlington Developmental Center is not in compliance with the IDEA.

Now, while I have told you about failure to comply with the Fourteenth Amendment, I am compelled to make one additional observation regarding the danger that Arlington residents currently face. The Court has indicated that in each of the areas cited by the United States, the United States has carried its burden of proof. But the Court should note specifically that in the medical care area, and in the area of direct staff supervision of patients or residents, conditions at Arlington Developmental Center pose an immediate danger of irreparable harm, including an active risk of death to patients at Arlington Developmental Center. Medical care within the institution, particularly for patients with seizure disorders, is so deviant from any recognized principles of medical care that any patient suffering prolonged seizures or status epilepticus may be in immediate peril of his or her life.

The testimony is virtually uncontradicted that no standard of care recognizes the administration of intramuscular valium for status epilepticus and that the only appropriate treatment for status epilepticus involving the use of valium is IV valium. Similarly, the failure of direct care staff to directly and properly supervise individuals with known behavior disorders, including eating disorders, has resulted in deaths which were entirely preventable. In fact, during these proceedings one resident of Arlington Developmental Center, Jane E., died. Jane E. died on Thursday, September 14, 1993, at 8:32 p.m., on the 9th day of the trial of this case. This is evidenced in Trial Exhibit 384. The cause of her death, the Court finds, was lack of supervision, complicated by lack of adequate emergency medical treatment.

While the State of Tennessee, it may be argued, has

begun to make improvements or to at least institute processes that might lead to improvements at Arlington Developmental Center, it does not appear that, at this time, those improvements have either been sufficiently implemented or are continuing to be implemented in such a way as to preclude the necessity of injunctive relief.

In analyzing the appropriate relief in this case, the plaintiffs argue that the defendants have demonstrated unwillingness to provide Arlington Developmental Center residents with constitutional levels of care. The United States further argues that their resistance to taking meaningful, voluntary corrective action is so pronounced as to be deliberate. Plaintiff points to the defendants' refusal to acknowledge the existence of deficiencies from the time of the issuance by the United States of its findings letter in March of 1991. The United States points to the extraordinary step taken by the Tennessee General Assembly to repeal state statutes that suggested that the defendants were responsible for the care of mentally retarded persons at Arlington Developmental Center.

There has been proof in this case, some of which has already been referred to, which supports the position taken by the United States During this case, there has been the late delivery by the State of Tennessee of documents sought in discovery, documents which were detrimental to the case presented by the State of Tennessee. It could be argued that there has been an effort, as demonstrated by Exhibit 414, by Arlington Developmental Center to misrepresent the nature of these proceedings and to frighten the families and friends of residents at Arlington Developmental Center.

There has been testimony by former employees of Arlington Developmental Center of an atmosphere of intimidation. One doctor, in his letter of resignation, addressed to Dr. Thomas McLemore of December 10, 1990, stated

> I have never before worked in such a climate such as exists at Arlington Developmental Center, the leadership is poor and one has difficulty in justifying some of the medical situations that seem to have to be tolerated because of administrative influence. It seems to me to be a lack of genuine concern by some of the administrative staff for the residents who live here and especially for the employees who are charged with their care. Sincerely yours, George P. Jones, M.D.

That is Exhibit 376.

Two highly sought after employees in psychology left Arlington Developmental Center when their efforts to compile and report to the administration a list of suspected physical and verbal abuse by direct care staff of Arlington Developmental Center were detected. The supervisor, Vickie Thompson, and her supervisor, Assistant Superintendent Robinson, upon learning of the list, demanded a copy and then another Arlington supervisory employee, Mr. Durr, gave copies of that list to the employees who were suspected of possible abuse, either physical or verbal. Two employees, Rebecca Palmer and Sherry Wilson, found that their jobs were made impossible, understandably, because of the actions of the administrators intent on protecting possible abusers as

opposed to protecting and disciplining individuals for that offense. In fact, Ms. Palmer was reprimanded for her action. No investigation was conducted regarding the employees who were identified as possible abusers. And I am not referring to some perfunctory review, I will talk about some of those later, but no meaningful investigation was conducted.

Ms. Wilson and Ms. Palmer both testified in these proceedings. Ms. Wilson has a Master's in Special Education and now works at Open Arms, a group home in the Frayser area of Memphis. Ms. Wilson testified regarding a lack of general care, a lack of interaction, and a lack of teaching at the institution. She observed poor feeding and bathing practices and observed, on occasion, five or six females in line naked in the bathroom. Vickie Thompson, the immediate supervisor, told Ms. Wilson, when Ms. Wilson inquired about the lack of care, that "I give staff rest time" between Medicaid reviews and Department of Justice inspections.

Rebecca Palmer also testified in this case. She has a Bachelor's degree in Psychology and is now a team leader at Southern Oklahoma Resource Center. She took a position at Arlington Developmental Center in January, 1991, and found the atmosphere negative and intimidating. She observed a lack of affection for residents, the use of harsh voice tones, and a severe lack of training. The staff which was charged with supervising residents spent time watching television, and Mr. Durr, as had Mrs. Thompson, gave the excuse that "we work hard during surveys, therefore, we don't work as hard at other times." Ms. Palmer observed that the residents were not treated with respect and that there was evidence of physical abuse. But as noted above, her efforts to initiate an investigation in that regard only resulted in her receiving a

reprimand and no meaningful investigation being conducted.

Ms. Palmer's husband, Roland Palmer, also worked at Arlington Developmental Center for the period January 11, 1991, through June 3, 1991. He is also now located in Oklahoma. But while at Arlington Developmental Center, he was the Director of Psychology. Vickie Thompson was his supervisor. When he arrived, he found a virtual absence of psychological services.

It is perhaps instructive to observe what the Superintendent of Arlington Developmental Center wrote to the Commissioner of Mental Health and Mental Retardation on January 7, 1991, regarding Mr. Palmer' She wrote as follows in advocating his retention by the institution:

> We cannot afford to lose the most qualified candidate recruited since May 1986, when the position was vacated. Further, this request is justified, [that was the request to deviate so they could employ Dr. Palmer], because of our critical need to have the required doctorial expertise as head of a service component impacting all individuals served at the facility. The Psychology Director is responsible for the overall development and implementation of facility-wide behavioral management strategies. It is the effectiveness of those strategies that allows the accomplishment of all other habilitative efforts. For four and one-half years, the continued absence of a Psychology Director has placed us in a vulnerable position in

> maintaining ICF/MR certification and accreditation. Considering our present Department of Justice investigation of the quality of our services, our time has run out. We must have a Psychology Director...

She went on to say

> Dr. Palmer has the directly related experience to meet our needs and is the only applicant having this experience to present reasonable salary expectations. Dr. Palmer has a total of four years, one month professional psychologist experience. Two years, two months of this experience was obtained at a facility under the same ICF/MR regulations as we must operate. He has a Ph.D. and masters degree in psychology, both with a concentration in mental retardation.

That letter was sent to Commissioner Taylor from Mona Reeves-Winfrey dated January 7, 1991, and is Exhibit 268 in this case.

Dr. Palmer testified in these proceedings as I have indicated he found the staff to have little professional training. He cited a number of examples, including that of a patient whose first name is Philip who had a behavioral disorder in which he struck the corner of tables with his head. This was a serious condition which Dr. Palmer immediately recognized. In fact, Dr. Palmer personally bought a helmet and trained staff regarding the use of the helmet in order to reduce the personal injury to Philip. Ironically, Thompson

and Riddel, employees at Arlington Developmental Center, attempted to oppose the use of the helmet, both displaying a lack of knowledge regarding the regulations concerning restraint, of which this helmet was not. Palmer made recommendations regarding obtaining psychiatric services, including the consultative services of a psychiatrist. He routinely found inadequate staffing, that is, one staff person to as many as 16 residents at Arlington, and routinely found staff watching television. He found poor and disruptive attitudes by the staff. When given the task of reviewing the Department of Justice findings letter, which has been marked as an exhibit in this case, Dr. Palmer's review was unsatisfactory to Arlington Developmental Center. That is, he reported that the Department of Justice was correct, and it appeared to Dr. Palmer that the Superintendent at that time concurred in his findings. But as you know, the conditions regarding the continued employment of Ms. Palmer, and as you may not know, the frustrations of Dr. Palmer in attempting to perform his duties at Arlington Developmental Center, led to their leaving Arlington Developmental Center. Of course, Rebecca Palmer, as you know, left Arlington Developmental Center because conditions had been made impossible and neither of them was allowed to exercise their professional judgment at the institution.

This attitude of obstruction within the institution was dramatically demonstrated in an incident which occurred on December 11, 1992, which is reflected in Exhibits 275 and 275A in this record. On December 11, 1992, shortly after noon, Lieutenant Robert Yoakum of the Tennessee Highway Patrol received a call from the state department, that is from the police department in Brownsville, Tennessee. The call was that two state vans had stopped at a store and the drivers had

purchased one quart of beer each and then proceeded toward Brownsville on Highway 19. The vans were loaded with residents from Arlington Developmental Center. The vans were stopped by Trooper Joe Crook and officer Mark Williams of the Haywood County Sheriff's Department.

Trooper Crook detected an odor of alcohol from each driver's breath. One of the drivers was Larry Williams, an employee of Arlington Developmental Center, who stated to Lieutenant Yoakum that both he and Cornell Willison had stopped at a store in Lauderdale County and had purchased a quart of beer each. Willison, the other driver who was also from Arlington Developmental Center, confirmed that they had both drunk a quart of beer each. Lieutenant Yoakum then called Mona Reeves-Winfrey, the superintendent of Arlington Developmental Center, and reported what had happened. He reported the drivers' condition and he further reported that each driver stated he knew the seriousness of his actions and that they had made an error in judgment.

The notes of the call made by Ms. Winfrey at the time of her conversation with Lieutenant Yoakum state "obviously, blown out of proportion." When the employees returned, they were not placed on suspension, but an investigation was conducted by June Stewart with a report to Edna Robinson. June Stewart, despite the admission of these two individuals, found that this was simply a case of misidentification and that the two Arlington employees had not purchased any beer at all. The report concluded

> On December 11, they were notified that no action was being taken in this matter and that they were to return to work on their next

scheduled work date of December 12, 1992.

See Trial Exhibit 275A for a full statement of the events. Ms. Reeves-Winfrey wrote the letter to the two employees confirming that "no action is deemed necessary on the part of Arlington Developmental Center." This was in spite of the fact that Ms. Reeves-Winfrey had talked directly with Lieutenant Yoakum and that she knew that there was no misidentification as reported by June Stewart in her report.

Ms. Stewart's report was a hastily done document with no inquiry to the State of Tennessee, with no investigation with Lieutenant Yoakum, and she obtained no documentation that was available readily from the State of Tennessee. Ms. June Stewart's report was consistent with the manner of doing business at Arlington Developmental Center.

The "Arlington way" is reflected in the recordation of injuries which were the subject of extensive testimony in this case. It is reflected in the conducted tours, and in the lack of services when third parties or inspectors are not present. It is reflected in the higher than normal mortality rate, the higher than normal injury rate, and the failure to effectuate any meaningful behavior modification programs for residents in need of that training. It is reflected by the fact that there is very little staff turnover and that there are very few, as evidenced by the testimony of the Superintendent, investigations of abuse, much less any discipline for resident abuse.

It is reflected in the testimony of the parents. In this case, a number of parents testified, and I don't disregard the testimony of those parents who hope for the best at Arlington

Developmental Center -- and I'm thankful that not every parent has had a terrible experience there with a devastating result -but, the testimony that is persuasive from the parents in this case was the testimony given by Carolyn Tucker whose daughter was admitted to Arlington Developmental Center, a happy, higher functioning individual at the institution who, because of a failure to provide proper treatment, and I'm not talking about a failure of judgment, I'm talking about a failure of any remotely correct medical judgment at all, is now unable to function. Those events, I'm sure for those of you who were here and heard the testimony, were particularly disturbing because Carolyn Tucker was on the phone, in fact, telling Dr. Herring the correct procedure for allowing her daughter to come out of status epilepticus. When the seizure began, in fact, Stevelyn Tucker had an aura and knew the seizure was to begin because that was how her seizures manifested themselves. Dr. Herring gave her Valium IM, that is intramuscularly. The testimony was simply overwhelming in the case, as I have previously indicated, that such a procedure is not effective in these circumstances. Most sadly, Carolyn Tucker was on the phone earlier that evening trying to locate her daughter whom she spoke to regularly most every evening. At first, there was some confusion about where she was, and ultimately she was able to talk to some of the medical personnel. She had told all of the medical personnel when her daughter was admitted in March of 1991, that when these events occurred, Stevelyn had in the past successfully been treated with Valium intravenously. She also had told them that Stevelyn had very severe seizures. On the phone that night, she told Dr. Herring they had to start Valium intravenously. That is, of course, the prescribed method of treatment. But the seizure continued for three or four hours. Dr. Herring did not start the proper procedure.

Ultimately, Stevelyn Tucker was transported to Le Bonheur Hospital where, of course, she lingered close to death. And now, one of the highest functioning individuals at that institution, a person who could speak, a person who could lead a close to normal life for someone in that circumstances, a person who had wanted to go to Arlington so she could be with people like herself because it was hard going to school in middle Tennessee and this was a better institution for her, that person now is deprived of any chance whatsoever of fulfilling those goals. It's a tragic thing that happened that day, but it was the Arlington way because Dr. Herring was not disciplined. In the mortality review, Dr. Herring was not sanctioned and he is still there at Arlington Developmental Center.

Jimmie Davis talked about her sister Bobbie. I brought the photographs of her sister here, Barbara S. I'm not going to show you those photographs because she has got terrible bruising, terrible bruising on the front of her body, black eyes. When she went to Arlington, that was not the circumstance. The superintendent, when confronted with the evidence, said she could not have done this to herself, and the Court agrees; but, the investigation blamed it on the resident, a common phenomenon at Arlington. Of course, the residents have trouble with credibility because they are there because of their mental or physical disabilities. No effective investigation was conducted.

Peggy Moore testified regarding her brother Mac. Mrs. Moore's mother is now 74 years old and she took care of Mac for approximately 40 years of his life. Mac was finally placed at Arlington. He was a large individual, apparently very gregarious, sat at the table, enjoyed eating with the

family. The family noted that he ate too fast, so they would say, "Mac, don't eat so fast," or "Mac, slow down, it's not going to go away." He would respond to that. Finally, because of his mother's advanced age and because of his disabilities, he was placed at Arlington. When he went to Arlington, he weighed about 230 pounds. He was a large person. He was also a very tall person. Arlington put him on a diet to where he eventually got down to 140. I think the diet just continued, nobody really monitored it that much. It was very inconvenient to have a large patient that they could not handle very well, although Mac could respond to verbal commands, but anyway, his weight was greatly reduced. He ultimately died as a result of his eating disorder.

Sheryl McCollum testified regarding her son Eric. There was other testimony about Eric in the record. Eric has two dislocated hips, but apparently that was not noted for some period of time at Arlington. Mrs. McCollum was understandably upset when she went on a recent visit to see him because she found him soaked in urine. It was not uncommon for people who made observations at Arlington to find situations in which patients had not been cleaned up, and on occasion, apparently Arlington personnel would say, "If we had known you were coming, we would have cleaned him or her up."

Sam Nuckolls testified in this case regarding his son. His son had severe disabilities, but had lived at home and had been taught a considerable amount of self-help. He had been taught to feed himself with a spoon. He had been taught to hold the cup and drink water from a straw. He had been taught to stand and they had worked hard so he could be an active and bright young man despite his disabilities. Mr.

Nuckolls determined that it was appropriate for his son to be placed at Arlington. I think it is fair to say that Arlington makes a good superficial presentation and that most individuals would expect that the institution could provide adequate care. His son was placed at Arlington and regressed greatly. He lost his ability to hold a cup or do those other things that he had been taught to do. The expert testimony establishes that in this case, individuals have to be trained repeatedly. They can't simply remember from long periods of time how to do a function. And if they are not consistently helped and reminded, if they do not use that function regularly, they will lose that part of their life which has been enriched. That happened with Mr. Nuckolls' son. An interesting thing also happened, they -- Mr. Nuckolls, of course, as with all parents, who are concerned about the health and welfare of their child -- wanted to strengthen his son's leg muscles and, so, bought a prone stander that allows the individual to be placed in a standing position. It improves muscle tone. It assists individuals to the degree that they can avoid regression and also, hopefully, have some actual improvement over long periods of time.

After awhile, he noticed that the leg stander seemed to always be in the same place when they came to visit his son. So he simply put something on the stander so he could see if anybody moved it or used it. And when they came back later, not immediately later, but some days later as you or I might now suspect, it had not been used. That device, which should be used on a regular basis, which physical therapy would require its use, was not used at all.

Peggy Ann Perkins Derringer also testified regarding her daughter Heather. Heather, when she went to Arlington

was able to ride a big wheel. She could walk and run and was a happy, bright child. She could swim. In fact, during that part of the testimony, or some part of the testimony, I asked about the pool at Arlington because I knew that they had a pool, but it turned out that it does not have any water in it and has not for a number of years. But anyway, she went to Arlington because her mother at the time could not continue to provide the care needed and they had a number of children. Her mother since has gone on to become, it is my recollection, a nurse, and is now, I believe, at St. Jude Hospital, or at one of the hospitals here in Memphis.

Her daughter is no longer at Arlington and has now had some surgery which considerably improved her condition. But, the reason that her daughter did not have that surgery earlier, the reason that her daughter did not have that surgery at Arlington - and let me say this about her situation, it was clear from the record that her daughter's condition at Arlington like the condition of other children that I have described, deteriorated at Arlington. Now, we all understand that there may be some deterioration with some of this patient population, but these individuals suffered deterioration which was not because of the natural progression of the condition, but was the result of a failure to provide appropriate care, a failure to provide physical therapy on a regular and consistent basis, a failure to provide any program which would allow them to continue or have some reasonable hope of continuing to have those few things in life which made life enjoyable or pleasant. Why didn't her daughter have the surgery while she was at Arlington? Why did she have it later? She didn't have that surgery because the doctor who recommended surgery to correct strictures that had occurred, because of the fact that her child had been placed in a wheelchair and not been

allowed to ambulate as she should have been allowed to ambulate, because the doctor told her, and it was part of the record in this case in Exhibit 202, and at least Arlington was on notice of this, even if it wasn't a major factor, but the doctor told her that Arlington couldn't provide appropriate follow-up care. It was because of the poor quality of physical therapy at Arlington Developmental Center. That's consistent with all of the testimony regarding physical therapy at Arlington Developmental Center.

All of these recent examples that I have given to you are examples of the Arlington way. A system designed, or a system that follows a policy of convenience for employees, of casting the blame on a resident where there might be some fault of an employee, a failure to investigate because there is a policy of virtually no discipline of employees at Arlington Developmental Center, in most cases.

A defense witness in this case, Dr. Philip Ziring, chairman of the Department of Pediatrics at Chicago Medical School, testified about the difficulty of changing an institutional culture. Dr. Ziring had been at Willowbrook, a very large institution in the State of New York, which, according to Dr. Ziring, was the institution, and the case that resulted in the enactment of CRIPA. Arlington Developmental Center has the same problems that Dr. Ziring identified at Willowbrook.

There are, of course, a number of specific actions which may be appropriate for a remedial order in this case. It is, however, the pervasive policy of elevating employee rights over the civil rights of residents that underlies the violations of rights in this case. The Court will enter a very brief

injunction, in essence, a preliminary injunction in this case to deal with the immediate threat to human life at Arlington Developmental Center. That order will be entered this afternoon and will be quite brief.

The Court will also enter a broader injunction after a 15-day opportunity for the State of Tennessee to comment on the proposed injunctive order submitted by the United States in this case. The Court finds that the injunctive order submitted by the United States generally covers those areas appropriate for relief in this case. Additionally, the Court will file additional findings of fact in this case to supplement the oral findings of the Court which were made here today. Finally, the Court will require the State of Tennessee, that is the Commissioner in this case, to submit a plan to remedy the violations of constitutional rights and the deprivation of educational opportunities found to exist in this case. That plan, after consultation with the United States, should be submitted by no later than Friday, January 21, 1994, at 5:00 p.m.[2]

Ladies and gentlemen, that concludes these proceedings for today.

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[2] The date by which the State of Tennessee shall submit a final remedial plan to the Court was extended to Friday, February 18, 1994, by court order filed December 23, 1993.

APPENDIX M

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 92-2062-M1/A

FILED
February 14, 1994
ROBERT R. DI TROLIO
CLERK, U.S. DIST. CT.
W.D. OF TEN, MEMPHIS

UNITED STATES OF AMERICA,)
Plaintiff,)
)
v.)
)
STATE OF TENNESSEE,)
Ned Wherter, Governor of the)
State of Tennessee; Evelyn C.)
Robertson, Jr., Director)
Tennessee Department of Mental)
Health and Mental Retardation;)
Mona Reeves-Winfrey,)
Superintendent, Arlington)
Developmental Center,)
Defendants.)
_____/

SUPPLEMENTAL FINDINGS OF FACT

These findings of fact supplement the Court's oral ruling delivered on November 22, 1993, and attached as Addendum I.

1. The Arlington Developmental Center (hereinafter "ADC") is a state operated, residential mental retardation facility housing approximately 432 developmentally disabled persons located in Arlington, Tennessee. (Christian, Tr. Vol. II at 149; Ex. 244.)

2. ADC's population consists primarily of individuals currently assessed as severely or profoundly retarded or developmentally disabled, some of whom have associated physical handicaps, medical problems, or behavior problems. (Hyman, Tr. Vol. III at 390-91; Ex. 244.)

3. Developmental disabilities include such conditions as cerebral palsy and mental retardation. (Hyman, Tr. Vol. III at 390-91.) Persons with mental retardation have substantial limitations in present functioning, characterized by significantly sub-average intellectual functioning existing concurrently with limitations in applicable adaptive skill areas, e.g., communication, self-care, social skills, self-direction, safety, functional academics, leisure and work. Mental retardation manifests before age 18. (Christian, Tr. Vol. I at 29.)

4. The functional capabilities, strengths and weaknesses of persons with mental retardation or other developmental disabilities cannot be determined absent appropriate evaluation, analysis and treatment

implementation, individualized to the particular person in question. (Christian, Tr. Vol. I at 43, 49; Szymanski, Tr. Vol. IV, generally and at 775-76, 878.)

5. Persons with developmental disabilities, including mental retardation, require treatment through the use of an individualized assessment and treatment plan, known as the Individual Habilitation Plan (IHP) at Arlington. (Christian, Tr. Vol. I at 49; Winfrey, Tr. at 136.)

6. Services for persons with developmental disabilities, including mental retardation, must be developed on an individual basis by a properly constituted interdisciplinary team. An interdisciplinary team must consist of, at a minimum, those individuals who provide both clinical and direct care services for the particular individual, including any specialty services, such as speech and hearing, communication, psychiatry, physical therapy, occupational therapy, and any others whose presence is necessary to ensure each individual's needs are met. (Hyman, Tr. Vol. III at 588; Christian, Tr. Vol. II at 155-56; Szymanski, Tr. Vol. IV at 811.)

7. ADC's mission statement and obligation is to provide a broad array of services to residents in accordance with their needs which are identified in Individualized Habilitation Plans which institutional staff design for each individual. (Reeves-Winfrey, Tr. at 135; Ex. 241-44, 258.)

8. Since early 1993, Arlington has been engaged in improving its data collection system, case management system, clinical aspects of behavior analysis, activities and training system on the Daniel Boone, Spruce, and Davy

Crockett units, and the quality management program, with the assistance of Behavior Management Consultants, Inc. Arlington plans to continue with those improvements and to expand them to all living units at ADC pursuant to a contract which extends to June 30, 1994. (Cox, Tr. at 287-90; Riordan, Tr. at 525-27; Mozingo, Tr. at 425-26; Reeves-Winfrey, Tr. at 53-5; Bailey, Tr. at 609.)

9. However, the evidence shows that the conditions at Arlington Developmental Center in 1990, 1991 and 1992, at the time of testimony (even after the improvements listed above) and continuing through the present, do not comply with minimal requirements under the Fourteenth Amendment. The Defendants fail to protect ADC residents from harm and fail to provide a safe and humane environment at ADC. (Christian rebuttal, Tr. at 2845.)

10. Defendants are failing to provide residents with reasonable care and a reasonably safe environment. ADC residents are subjected to serious harm and undue risks of harm due to inadequate supervision which results, at least in part, from insufficient numbers of staff and inadequate training of the staff available given the current number of residents at the facility. (Christian, Tr. Vol. I at 48, 62-3, 67-8, 72; Christian, Tr. Vol. II at 261; Christian rebuttal, Tr. at 2766.)

11. During the past three years, ADC's own records demonstrate that there have been over 6100 reported injuries to ADC residents. (Christian, Tr. Vol. I at 79-80; Ex. 6, 7.)

12. Arlington has a system of policies and

procedures for documenting incidents and injuries in which residents are involved. (Cox, Tr. at 307-09, 331; Reeves-Winfrey, Tr. at 6465; Bailey, Tr. at 685-86; Ex. 285, 286.) Arlington compiles statistics concerning incidents and injuries, and analyzes the data for identification of trends and ways to possibly reduce the incident rate. (Cox, Tr. at 308-14; Reeves-Winfrey, Tr. at 6971; Ex. 287, 288.) However, ADC's recordkeeping system is inadequate and inaccurate. Thus, the 6100 reported injuries under-represents the actual number of injuries that occurred at ADC. (Christian, Tr. Vol. I at 85-86; Christian, Tr. Vol. II at 305-06; Reeves-Winfrey, Tr. at 186-97; Cox, Tr. at 394-411; Ex. 11.)

13. The ADC staff is not properly trained and accordingly they do not accurately record injuries or report them in a uniform manner. This results in data collection which is insufficient to develop behavior development plans. (Christian, Tr. Vol. I at 84-90; Christian rebuttal, Tr. at 2766-83; Cox, Tr. at 394; Ex. 295.)

14. Defendants fail to meet their own direct care staff[1] to resident ratios on three shifts of 1:4 (day), 1:4 (evening) and 1:8 (night); ratios are regularly much higher than that, at times as high as one staff member for 16 residents. (Christian, Tr. Vol. I at 64, 66; Ex. 3-5; Christian rebuttal, Tr. at 2763-64, 2766-68; Reeves-Winfrey, Tr. at 136-37, 149-50.) Even where 1:4 staffing was present, direct care staff members often worked with only a single

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[1] The term "direct care staff" includes Developmental Technicians (DTs) and Developmental Technician Trainers (DTTs) as described in the Superintendent's testimony.

individual, leaving many others idle. (Christian, Tr. Vol. I at 69; Christian, Tr. Vol. II at 226-28; Christian rebuttal, Tr. at 2762-64; Ex. 24, 26, 428.)

15. The training and skills of direct care staff are grossly substandard. (Christian, Tr. Vol. I at 48, 68; Rol. Palmer, Tr. Vol. II at 1347-49.) Direct care staff and supervisors need additional training in recording and reporting of injuries, and in the supervision of residents sufficient to ensure the residents' safety. (Christian rebuttal, Tr. at 2766--68.) Many direct care staff do not fulfill their responsibilities for the care of the residents entrusted to them. (Ex. 24, 25.) Direct care staff often leave residents unattended or ignore residents when they require attention, particularly when they are engaging in self-injurious behaviors. (Christian, Tr. Vol. II at 194-95; Christian rebuttal, Tr. at 2773-74.)

16. Many of the injuries suffered by ADC residents are serious, including numerous major fractures, lacerations, which required stitches, and major bruises and abrasions. Residents have also lost their sight. Examples of such injuries are: Sandra H. and Mary B. lost sight in at least one eye from altercations with other residents. (Christian, Tr. Vol. I at 92.) Grace M.'s elbow was pulverized. (Christian, Tr. Vol. I at 88.) Ronny S., a blind resident, lost part of a finger when another resident slammed a door on it. Anthony W. broke his arm in a shower; Dottie B. broke six ribs. There are a number of fractures of unknown origin. Residents (e.g. Gary B., M.G.H.) were "discovered" with lacerations and large bruises which ADC lists as of unknown origin. (Christian, Tr. Vol. I at 97;
Ex. 9-10.)

17. ADC's supervision is so deficient that one resident, Adrian J., was bitten 22 times by another resident in a single incident. (Christian, Tr. Vol. I at 97; Bailey, Tr. at 860; Ex. 6-7, 9-10, 20, 23, 127-95.) As of March 1993, Adrian was still being bitten.[2]

18. In addition to these severe injuries, ADC residents suffered thousands of other injuries during this period. These injuries included cuts, scratches, abrasions, bruises, and bumps. (Ex. 6, 186-90, 193-95.)

19. Defendants identify many of the injuries to ADC residents as from "unknown" causes, meaning no staff were present at the time the injury occurred to witness the event. (Christian, Tr. Vol. I at 80-81; Cox, Tr. at 385-402; Ex. 6-7, 10.)

20. Defendants do not sufficiently investigate and respond to injuries to residents and permit repeated injuries to the same residents. (Reeves-Winfrey, Tr. at 186-92; Cox, Tr. at 373, 391, 393; Davis, Tr. at 1792-93; Ex. 23, 127-90, 193-95, 270.)

21. Staffing ratios for clients such as the majority of those at ADC should be no less than that required to reasonably ensure the safety of the residents. A ratio of 1:4 is a general guideline, but many residents with self-injurious or

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[2] Examples identified in these proposed findings of fact do not constitute a complete recitation of all incidents supporting a particular finding. The examples are simply illustrations of the deficiencies supported in the record.

aggressive behavior may require higher staffing ratios, including some who require 1:1 ratios for the safety of themselves and other residents. (Christian, Tr. Vol. II at 308, 311-12, 316; Rol. Palmer, Tr. Vol. VII at 1346-47.)

22. ADC does not appropriately investigate or pursue reported instances of abuse (or severe neglect which could amount to abuse) of residents by staff members. (Rol. Palmer, Tr. Vol. VII at 1432-41; Derringer, Tr. Vol. IX at 1861-68, 1871; McCollum, Tr. Vol. IX at 1839-51; Davis, Tr. Vol. IX at 1788-1802; Rol. Palmer, Tr. Vol. VII at 1354; 90, 127-90, 193-95.)

23. Conditions at ADC regarding reasonable care and safety are a substantial departure from accepted professional judgment, practice or standards. These conditions continue to be unsafe, subjecting residents to injury or a serious risk of injury. (Christian, Tr. Vol. I at 56-58; Christian rebuttal, Tr. at 2767.)

DEFENDANTS' HABILITATION, AND PSYCHOLOGICAL SERVICES AND RELATED TRAINING ARE SERIOUSLY DEFICIENT

24. Defendants' habilitation, psychology services, and training for these services are a substantial departure from accepted professional judgment, practice or standards. (Christian, Tr. Vol. II at 262.)

25. Arlington employs an interim Assistant Superintendent for Programming Services who also serves as Director of Psychology. (Cox, Tr. at 268.) In the psychology department, there are positions for three staff behavior

management specialists, one additional Ph.D. staff psychologist, six master's level staff psychological examiners, and six staff counselling associates. In addition, there are contracts for part-time work for one Ph.D. counselling psychologist and two master's level psychological examiners, and two graduate students also provide assistance. (Cox, Tr. at 271-72.) Three of the positions for psychological examiner are currently unfilled. (Cox, Tr. at 273.)

26. Defendants fail to regulate and review the use of restraints, in any meaningful way, which cause harm to ADC residents or subjects them to significant risk of harm. (Christian rebuttal, Tr. at 2794, 2818-21.)

27. Many residents of ADC exhibit behavior problems and injure themselves or others. Professionally developed and implemented behavioral training programs, referred to as Behavior Development Programs (BDPs) at ADC, are generally accepted by professionals as the means of addressing, ameliorating and eliminating, to the extent possible, maladaptive behaviors. (Christian, Tr. Vol. I at 120-23, 125, 126; Christian Tr. Vol. II at 257.)

28. Very few of the BDPs at ADC provide replacement behaviors or skill acquisition components as professionally required. Additionally, ADC programs are deficient in properly analyzing the causes of maladaptive behaviors, e.g., there is no functional analysis. (Christian, Tr. Vol. II at 186-87, 257-58; Rol. Palmer, Tr. Vol. VII at 1324; See Ex. 92 (ADC informed of need for functional analysis by staff psychologist in 1991).)

29. As a result of inappropriate staff responses to

resident behaviors, such as rewarding inappropriate behavior or failing to reinforce appropriate behavior, residents develop and continue dangerous maladaptive behaviors which, in turn, lead to increased numbers of injuries. (Christian, Tr. Vol. II at 194-95, 203-10, 327, 335; See Ex. 14, 31.)

30. Defendants' failure to provide and implement adequate training programs has led to residents engaging in self-injurious, aggressive or other dangerous behaviors. (Christian, Tr. Vol. I at 81; Tr. at 625 (staff must be constantly vigilant); See Ex. 21, 14, 31.) Residents have gouged their faces, destroyed their ears, cut and bruised themselves and broken arms and ribs. (Ex. 6, 7, 127-190, 193-95.)

31. Examples of injuries occurring as a result of ADC's failure to provide appropriate programs include: Philip R. banged his head so frequently that his lower jaw was constantly injured, open, or covered with scar tissue. He subsequently died. (Christian, Tr. Vol. I at 108; Christian, Tr. Vol. II at 306, 340.) Resident Harry J. picks at a "hole" he has developed on his cheek from his maladaptive behavior. Although this resident continues to pick at the hole in his cheek, his program has been discontinued. (Christian, Tr. Vol. I at 106; Christian, Tr. Vol. II at 164.) Leroy P. has had repeated surgeries to remove plastic bags and other objects he has ingested from his intestinal tract. (Christian, Tr. Vol. I at 108, Christian, Tr. Vol. II at 172-73.) Other residents have vomited foreign objects they have eaten. Carol W. bangs her nose and hand mouths. (Christian, Tr. Vol. II at 171-72; Mozingo, Tr. at 500-01; Ex. 24.) Dwight C. bites numerous residents, some on multiple occasions. (Christian, Tr. Vol. II at 178-80; Ex. 23.) Other residents exhibit significant scarring

from the multiple, repeated injuries each has suffered. (Ex. 6, 7, 12, 13.)

32. Defendants are failing to provide individualized, professionally designed behavior programs to all of the residents of ADC who need or can benefit from them. This is due, in part, to defendant's failure to recognize both the severity of residents' behaviors (Christian, Tr. Vol. I at 48-49 and their capacity for growth and development. (See Ex. 308.) Presently, only 68 ADC residents have behavior training programs. Many more residents need such programs. (Christian, Tr. Vol. I at 130; Rol. Palmer, Tr. Vol. VII at 1324; Ex. 18, 88.)

33. Programs to teach adaptive behaviors, including self-help skills, communication, social skills, and skills to enhance independence, are essential to the physical and mental health and safety of residents. Such programs are not professionally designed and/or implemented at ADC. (Christian, Tr. Vol. I at 31; Christian, Tr. Vol. II at 122-23, 256, 261; Szymanski, Tr. Vol. IV at 809-10.)

34. Defendants' failure to provide and implement programs which both reduce and replace maladaptive behavior and foster acquisition and maintenance of adaptive behaviors, due to the lack of adequate numbers of properly trained and supervised staff, has led to an increase in serious maladaptive behaviors by residents that has resulted in injuries to themselves and other residents. (Christian, Tr. Vol. I at 48; Vol. II at 190-91, 26162.)

35. Defendants' behavior programs focus solely on the reduction of inappropriate behaviors. (Szymanski, Tr.

Vol. IV at 782.) The psychiatrists and psychologists at ADC are not involved in the planning for total programming, including skill acquisition. (Szymanski, Tr. Vol. V at 877-78, 937.)

36. Idleness among persons with developmental disabilities may lead to the development of maladaptive behaviors even in residents who do not currently exhibit such behaviors. (Christian, Tr. Vol. II at 192-94, 262.) Many ADC residents sit idle for prolonged periods of time with nothing to do and without any stimulating interaction with staff. (Christian, Tr. Vol. II at 194-96; Szymanski, Tr. Vol. V at 822-24; Christian rebuttal, Tr. at 2763.)

37. ADC does not provide residents at ADC (including those who are nonverbal and/or nonambulatory) needed, consistent, positive interaction. (Christian, Tr. Vol. II at 162; Rol. Palmer, Tr. Vol. VII at 1348; Ex. 90, 91.)

38. No psychologist at ADC, including the Director of Psychology, has the necessary experience in behavioral psychology or has been adequately trained in behavioral psychology. (Christian, Tr. Vol. II at 257, 301-02.) As the consequence, they are not able to adequately develop and implement training programs for residents with aggressive, self-abusive and other dangerous behaviors. (Christian, Tr. Vol. II at 278-79, 301-02.)

39. The few programs on the Daniel Boone unit, ADC's "model unit" for behavior training, are deficient in that they fail to adequately address skill acquisition, they are not based upon reliable, objective criteria and accurate data, (Cox, Tr. at 395-97, 402.) and they are not being

appropriately and consistently implemented. (Riordan, Tr. at 566-67; Christian rebuttal, Tr. at 2767-69.)

40. Lack of adequately trained direct care staff has led to direct care staff being unfamiliar with the training programs for those residents for whose care they are responsible. (Rol. Palmer, Tr. Vol. VII at 1347; Christian rebuttal, Tr. at 2760, 2766, 2768.) This results in programs not being followed or properly implemented. Additionally, some direct care staff simply fail to implement training programs. (Christian rebuttal, Tr. at 2772-73, 2784-86, 2801-03.)

41. Defendant's failure to monitor and regulate the use of restraints, both physical and chemical, at ADC is a substantial departure from professional judgment, practice, or standards. (Cox, Tr. at 376-80, 383-84; Rol. Palmer, Tr. Vol. VII at 1338-39; Christian rebuttal, Tr. at 2818-20; Ex. 289, 290.)

42. Defendants have no restraint log, making necessary behavior management and human rights review of restraint usage at ADC impossible. (Christian, Tr. Vol. I at 51, 53; Christian rebuttal, Tr. at 2818.) Residents are subjected to physical restraints, i.e., helmets or mitts, to control their self-destructive behaviors in lieu of training programs designed to reduce or eliminate such behaviors. In other cases, Defendants are failing to use restraints temporarily with an appropriate behavior program even where residents are exposed to serious, potentially life-threatening danger. (Rol. Palmer, Tr. at 132732; Christian rebuttal, Tr. at 2821.)

43. The Behavior Management and Human Rights Committees at ADC do not function in a professional manner (Christian, Tr. Vol. I at 56; Christian Vol. II at 233-35, 239, 260-61.) and exercise no professional judgment.

44. Many injuries, the use of restraints, and the intensity of maladaptive behaviors exhibited by residents could be prevented or ameliorated if residents had appropriate training programs and Defendants provided sufficient numbers of adequately trained staff to implement them. (Christian, Tr. Vol. II at 261-62; Christian rebuttal, Tr. at 2844-45; See Ex. 14, 31.)

45. Defendants' failure to review and update residents' training programs is due, in part, to insufficient numbers of psychologists and other professional staff at ADC, as well as inadequately trained professional staff, as stated above. (Christian, Tr. Vol. II at 243.)

46. Notwithstanding Defendants' claims that improvements in training and psychological services have recently been made, habilitation and training programs and psychological services, even on Daniel Boone unit, continue to be a substantial departure from accepted judgment, practice or standards, which subject residents to harm. (Christian, Tr. Vol. II at 262; Christian rebuttal, Tr. at 2766-67.)

MEDICAL CARE AND RELATED HEALTH SERVICES ARE GROSSLY DEFICIENT

47. Defendants' medical care and related health services in those areas listed below are grossly deficient, and are resulting in unnecessary resident illnesses, deformities,

suffering and death.

48. Arlington employs four full-time primary care physicians and a medical director, each appropriately licensed. There is a fifth physician position that is currently unfilled. On-site physician coverage is provided 24 hours a day, seven days a week. (McLemore, Tr. at 1700-02.)

49. Within 24 hours of admission, each new resident receives a physical examination by one of the staff physicians, including a comprehensive array of routine tests, as well as tests pertinent to the resident's specific medical conditions. Thereafter, routine physical examinations and standard lab tests are performed on an annual basis. All residents receive routine immunizations, including immunizations against hepatitis. Residents are provided with routine gynecological and ophthalmological exams and mammograms. (McLemore, Tr. at 1702-05, 1710-11.)

50. On-site resources include a pharmacy, laboratory, x-ray (24 hours a day/7 days a week), EEG, EKG, ultrasound, and mammography. Other specialized diagnostic testing is available at area hospitals. Laboratory test results are obtained overnight or can be obtained on an immediate basis, as needed. (McLemore, Tr. at 1710-11.)

51. Regular, on-site specialty consultation clinics are currently conducted in neurology, psychiatry, ophthalmology, gynecology, and gastroenterology. A broad array of other off-site specialty consultations are also available and regularly utilized. There are no outside medical consultations providing needed services that Arlington is unable to obtain. (McLemore, Tr. at 1712-14.)

52. The system of primary health care at Arlington is a residential model, with each physician assigned a specific living unit/caseload. (McLemore, Tr. at 1706.) Daily rounds to each living unit by each physician are one aspect of the system for identifying potential medical problems and follow-up and monitoring of previously identified conditions. (McLemore, Tr. at 1706, 1723.) Laboratory reports and reports from specialized consultations are delivered to the nursing clinics located in each living unit area, are available during daily rounds, and are to be reviewed by the physician and placed in the resident's chart. (McLemore, Tr. at 1715-16.)

53. Defendants have recently signed a one year contract with the University of Tennessee to provide some essential medical services to ADC residents, the terms of the contract are conditional and for no longer than one year. (Hyman, Tr. Vol. IV at 624-25.)

54. Notwithstanding Defendants' claims that improvements have recently been made in the provision of medical care, any such improvements have not remedied the grossly inadequate care, which continues to subject residents to avoidable suffering, morbidity and mortality. (Hyman, Tr. Vol. IV at 648.)

Feeding Practices and Medical Management of Feeding-Related Disorders

55. Defendants' feeding practices at Arlington are dangerous, life-threatening, result in harm to residents, and continue to place residents at unreasonable risk of harm. These practices are a substantial departure from accepted

professional standards or practices. (Hyman, Tr. Vol. III at 403-05, 417; Therriault, Tr. Vol. V at 993; and McEwen, Tr. Vol. VI at 1237-38.)

56. Such practices (e.g., bird feeding; inappropriately positioning residents before, during and after meals; feeding residents too much, too fast, the wrong diet or food of inappropriate texture; and inadequately supervising residents while they are eating) have caused, and continue to cause, increased risk of reflux, gagging, choking, aspiration, aspiration pneumonia, asphyxiation and death among ADC residents. (McEwen, Tr. Vol. VI at 1237-38; Hyman, Tr. Vol. III at 403-17; Therriault, Tr. Vol. V at 1000-01, 1008-16; Hinkle, Tr. at 2075-76, 2084-92; Hyman, video rebuttal Ex. 441; McEwen rebuttal, Tr. at 2912-14; Therriault rebuttal, Tr. at 2868-69.)

57. ADC places residents in bed immediately after they have eaten, a practice which increases the risk of reflux, choking and aspiration. (Hyman, Tr. Vol. III at 405; Drews, Tr. at 1245-1246.) This practice, euphemistically termed "bedroom leisure" by ADC (See Therriault, rebuttal, Tr. at 2884), is medically inappropriate and serves no legitimate medical or programming purpose and is a substantial departure from accepted professional standards. (Hyman, Tr. Vol. III at 403-05.)

58. Significant measures have been taken within the last year to address the seating/positioning needs of residents as they relate to feeding. (Payne, Tr. at 955-56; Hyman, Tr. Vol ~ IV at 679-85; See Ex. 53-57, 327.) A number of facility-wide changes related to staff position while feeding, portion control, pace of feeding, increased individualization

of feeding techniques, increased use of appropriate adaptive equipment, and improved positioning of residents through changes in adaptive seating systems, has resulted in some reduction in inappropriate feeding practices. (Drews, Tr. at 1240-43; Hinkle, Tr. at 2033-38.) However, dangerous feeding practices at ADC are still life-threatening and result in harm to residents. (Hyman, Tr. Vol. III at 403-05; Therriault rebuttal, Tr. at 2869.)

59. Even though some of ADC residents have feeding programs, there are too few properly trained staff to effectively implement the programs. (McEwen, Tr. Vol. VI at 1237-38; Hyman, Tr. Vol. III at 408-12; Therriault, Tr. Vol. V at 1034-36; McEwen rebuttal, Tr. at 2910-14; Hyman video rebuttal Ex. 441; Therriault rebuttal, Tr. at 2868-78.)

60. With the recent staff increase at ADC, there are now two full-time swallowing therapists, both speech pathologists. (Andreas, Tr. at 1086; Hinkle, Tr. at 2032.) There are also three full-time speech pathologists who function part-time as swallowing therapists and three occupational therapists (two part-time) who function as swallowing therapists a portion of each day and a part-time feeding therapist consultant. (Hinkle, Tr. at 2032-33.) The swallowing therapist's dual role is to provide direct feeding-related services and to act as case managers to ensure that the components of the dysphagia management system are coordinated to meet the multi-disciplinary needs of the residents. (See Andreas, Tr. at 1052-58, 1069-71.) Both direct and consultative services are being provided by William Hinkle, Ph.D. (Hyman, Tr. Vol. III at 431; Hyman, Tr. Vol. IV at 664, 672; Andreas, Tr. at 957.)

61. Following an initial facility-wide screening to prioritize at-risk individuals (Hinkle, Tr. at 2013), three basic methods now result in a resident's entry into the feeding/swallowing management system: referrals from staff and the team process; the swallowing ~ therapist's systematic review of all dining plans in all living units; and evaluation at the time of each resident's annual staffing. (Hinkle, Tr. at 2013-15, 2019; Andreas, Tr. at 1052.) Newly developed dining plans exist for many residents and the process is on-going. (Hinkle, Tr. at 2018-19.)

62. However, these newly developed resident "dining plans," which indicate that individual staff members have been trained to implement individual feeding programs, contain multiple irregularities and staff give inconsistent statements about the training they have actually received. Some staff admitted they had not been trained, and even those that said they had received training did not follow the practices listed in the plans as they fed residents. (Hyman, Tr. Vol. III at 410-13; Therriault, Tr. Vol. V at 1020-22, 1029-36; McEwen rebuttal, Tr. at 1920-12; Therriault rebuttal, Tr. at 2870-72; and Hyman, video rebuttal Ex. 441.)

63. Sufficient numbers of adequately trained staff are not available at Arlington to monitor residents at mealtimes (Hyman, Tr. Vol. III at 464, 469, 489) and while the residents are in postural drainage. (Hyman, Tr. Vol. III at 492; Hyman, video rebuttal Ex. 441.)

64. Defendants' use of postural drainage at Arlington (i.e., placing residents in a head down position for long periods of time unattended) is dangerous and subjects residents to substantial risk of harm. (Hyman, Tr. Vol. III at

492-94.)

65. Defendants fail to provide proper medical management of residents with feeding-related disorders and illnesses, including dysphagia, reflux and respiratory illnesses associated with aspiration and reflux. (Hyman, Tr. Vol. III at 429-30.) Defendants' failure to properly diagnose and treat these disorders has harmed residents and continues to harm residents and place residents at unreasonable risk of harm. (Hyman, Tr. Vol. III at 429-35.)

66. Although fully apprised of these dangerous practices by the United States on a number of different occasions, Defendants failed to take sufficient steps to eliminate them. (Hyman, Tr. Vol. III at 435.) Defendants' failure to act, even upon their own consultants' recommendations, has resulted in residents suffering unnecessary illnesses and even death. (Hyman, Tr. Vol. III at 445-50, 478-80.)

67. At least 28 residents have died from aspiration or reflux related causes within the last six years, and in many of these cases inadequate and improper care and medical treatment directly contributed to the continuing ill health and deaths of these residents. (Hyman, Tr. Vol. III at 450-60, 463-65, 469-71, 476-91)

Vision, Hearing and Communication

68. Defendants fail to adequately provide for the visual, hearing and communication needs of the residents, (Christian, Tr. Vol. II at 159), preventing or at least significantly limiting residents with these needs from

benefitting from any educational, behavior modification, or social affective programs or any other training or programming. (Szymanski, Tr. Vol. IV at 788-90.)

Acute and Chronic Seizure Management

69. The management of residents with chronic seizures is a substantial departure from professionally accepted clinical practice. (Hyman, Tr. Vol. III at 388-89, 501, 507, 546-47.) Defendants do not properly monitor and treat ADC residents with seizure disorders. ADC keeps residents on anticonvulsants they no longer need, keeps them on sub-therapeutic or potentially toxic levels of medication for months (and in some cases, a year or more) with no rationale documenting the efficacy of this for the residents involved. (Hyman, Tr. Vol. III at 501-74.)

70. Residents who have not had seizures for over six years are kept on one or more anticonvulsant, exposing them to the potentially harmful side effects of these medications, with no documentation as to why such medication has been continued and without plans to reduce the number of medications. (Hyman, Tr. Vol. III at 503-10.) ADC fails to monitor blood levels to ensure that medication levels are appropriate. (Hyman, Tr. Vol. III at 512-28, 530-38.)

71. ADC does not adequately track seizures and seizure medication to ensure that a record is maintained of each seizure. Proper tracking is necessary to ensure appropriate use of medication. (Hyman, Tro Vol. III at 502-03; Therriault, Tr. Vol. III at 1641-43; Hyman rebuttal Tr. at 2892, 2896.)

72. Although many residents are maintained on one anticonvulsant medication (monotherapy), some residents are inappropriately maintained on more than one anticonvulsant medication (polypharmacy) for years without requisite plans to reduce the number of medications. (Hyman, Tr. Vol. III at 504, 530, 534-41.) In several cases where monotherapy has been recently attempted and has failed (i.e., in some cases one medication is not sufficient to control the individuals' seizures), ADC physicians have failed to recognize the limitations of monotherapy for these residents and have continued to leave them on one anticonvulsant despite significant increases in these residents' seizures once monotherapy began, resulting in harm to these residents. (Hyman, Tr. Vol. III at 518-20, 541-43, 545-47, 571-72.)

73. Defendants' emergency response and medical treatment of acute seizure events is grossly inadequate. For example, ADC medical staff continue to treat status epilepticus, a condition with a high rate of morbidity and mortality, with intra-muscular (I.M.) medications -- a practice soundly rejected by the medical profession. (Hyman, Tr. Vol. III at 547-48, 550-51, 556, 566-71.) In one case, a higher-functioning, 15 year-old was treated with only I.M. valium during a three hour seizure. The inappropriate treatment resulted in severe, irreversible brain damage. (Hyman, Tr. Vol. III at 551-66.)

74. ADC physicians have inadequate experience with and lack of basic knowledge of both chronic and acute seizure management, and fail to properly utilize outside consultants, resulting in harm to residents and placing residents at substantial risk of harm. (Hyman, Tr. Vol. III at 534, 542, 573-78.)

Medication Use and Monitoring

75. Defendants' failures to prescribe medications appropriately, to adequately monitor blood levels, and to recognize and monitor harmful side effects is a substantial departure from accepted judgment, practice or standards and has harmed residents and continues to harm residents and place them at substantial risk of harm. (Hyman, Tr. at 580-87; Hyman, Tr. Vol. IV at 597-02, 604-13; Hyman, video rebuttal Ex. 441.)

76. Various medications, medical procedures, and their effects are not understood or appreciated by ADC's medical staff. For example, the blood level of one resident was not monitored appropriately and she died of theophylline toxicity. (Hyman, Tr. at vol. III at 597-02.) Another resident was given four enemas in a 12 hour period and subsequently died from the effects of a high sodium level caused by the enema solution. (Hyman, Tr.Vol. III at 582-86.) Another resident was maintained on a toxic level of a psychotropic, stelazine, resulting in serious physical and behavioral side effects, and perhaps contributing to his choking to death because of the drug's known effect to increase appetite and decrease swallowing and gagging reflexes. (Hyman, Tr. Vol. IV at 604-13.)

Orthopedic Management

77. Defendants fail to provide timely and accurate diagnoses and treatment for acute orthopedic trauma, as well as for chronic and progressive orthopedic disorders, resulting in residents suffering unnecessary pain, disfigurement and loss of mobility and function. (Hyman, Tr. Vol. IV at 619-20,

632-33, 637-47.)

78. Defendants misdiagnose fractures and fail to diagnose them in a timely fashion. (Hyman, Tr. Vol. IV at 645, 647.)

Training and Response to Medical Emergencies

79. Staff training for and responses to medical emergencies at ADC are grossly inadequate, have harmed residents and continue to place residents at an unreasonable risk of harm. (Hyman, Tr. Vol. III at 441-44, 464, 469-70, 552-56; Hyman, video rebuttal Ex. 441.)

Peer Review, Including Mortality Review

80. Defendants' investigations of injuries, abuse allegations and deaths are perfunctory, and rarely result in any corrective action. The causes or circumstances of an inordinate number of serious incidents, injuries, and deaths are unknown and unexplained. (Hyman, Tr. Vol. III at 558-66; Vol. IV at 602, 613; Christian, Tr. Vol. I at 97, 99; Rol. Palmer, Vol. VII at 1390-91; Rol. Palmer, Tr. Vol. VII at 1433-41.)

Medical Staffing and Use of Consultants

81. There are too few adequately trained and supervised medical personnel at ADC. (Hyman, Tr. at 410-12, 418, 435, 480; Christian, Tr. Vol. I at 48, 72, 127; Christian, Tr. Vol. II at 257.)

82. Defendants fail to employ or utilize needed

medical consultants, (Hyman, Tr. Vol. III at 578), and, in those cases where they do seek consultants' recommendations, they do not act upon them quickly, if at all. (Hyman, Tr. Vol. III at 448-49; Hyman, Tr. Vol. IV at 648-49.)

Documentation

83. Defendants' documentation of medical diagnoses, treatment, and follow-up for individual residents, as well as Defendants' statistical reports, are grossly inadequate (Hyman, Tr. Vol. III at 447-49, 453, 481-83, 514-15), and often inaccurate, and have harmed residents, and continue to harm residents and place them at unreasonable risk of harm. (Hyman, Tr. Vol. III at 508-09.)

84. The nurses at Arlington, though, who act as "gate keepers" for the physicians, are generally not doing an adequate job of placing into the resident charts the information needed by the physicians in order to exercise their professional judgment. (Hyman, Tr. at 502.)

Community Placement

85. None of the medical staff at ADC are charged with or are taking the responsibility to evaluate or coordinate resident discharges into the community in light of their potential medical need. (McLemore, Tr. at 1898-1905.) Although community placement may be appropriate for residents of ADC and may serve to foster the resident's growth and development, Defendants' placement process or "dumping" does not reflect the exercise of professional judgment.

DEFENDANTS ARE FAILING TO PROVIDE ADEQUATE PSYCHIATRIC SERVICES FOR RESIDENTS

86. Defendants are failing to provide adequate psychiatric services because ADC cannot provide accurate and reliable information upon which a psychiatrist may base treatment decisions, including the use of psychotropic drugs. (Christian, Tr. at 2761.)

87. Since the addition of Dr. Horwitz in October, 1992, and the contract with Dr. Levine in the summer of 1993, Arlington has been providing psychiatric care to its residents through the services of two psychiatrists, who are employed by Arlington as consultants. (Horowitz, Tr. at 1342; Levine, Tr. at 1601.) However, defendants still fail, inter alia, to implement professionally designed training programs, to recognize and conduct proper assessments of residents needing psychological services, to train staff, and to have sufficient numbers of trained staff (both professional and direct care). (Christian, generally and Tr. Vol. I at 48; Christian, Tr. Vol. II at 262; Christian rebuttal, Tr. at 2761, 2766-68.)

88. Integration of psychiatry into interdisciplinary team approaches to the provision of services to persons with mental retardation has been the practice in the field of mental retardation for over twenty years. (Szymanski, Tr. Vol. IV at 809, 811-12; See Ex. 349.)

89. Persons with mental retardation have the same mental health needs as persons without mental retardation -- but more intense due to their deficits and their dependence on

others. (Szymanski, Tr. Vol. IV at 768.) At ADC, psychiatric recommendations for residents are not made as part of a program developed by an interdisciplinary team, which is necessary for such psychiatric care to be appropriate or meaningful. (Szymanski, Tr. Vol. IV at 809, 811-12.)

90. Severe behavior disorders in individuals with mental retardation may be treated without medication and should only be treated with medication if there is evidence that the behavior relates to an underlying mental disease. In addition, behavioral training is required even if a person is receiving medication for a severe behavior disorder. (Szymanski, Tr. Vol. V at 830.)

91. Defendants use psychotropic medications without adequate justification of the effectiveness or necessity for such drugs. (Szymanski, Tr. Vol. V at 891-92.)

92. Psychiatrists prescribe psychotropic and other potentially dangerous medications for ADC residents without the opportunity to conduct complete examinations and assessments of residents due to severe time limitations. (Szymanski, Tr. Vol. IV at 784-85; Szymanski, Tr. Vol. V at 830-32, 836-37, 842.)

93. Defendants' fail to obtain information necessary to provide mental health services at ADC, e.g., psychiatric history, initial diagnostic assessment, and etiological acquisition. (Szymanski, Tr. Vol. IV at 784, 838, 842.)

94. Accurate and reliable data is necessary to determine the efficacy of treatments, both psychiatric and

behavioral, for residents. Such data is not kept at ADC. (Szymanski, Tr. Vol. VI at 792, 801-02, 806, 810, 812; Vol. V at 861-62; Rol. Palmer, Tr. Vol. VII at 1326.)

95. Defendants fail to provide sufficient psychiatric consultation time to provide necessary psychiatric and mental health services to residents. (Szymanski, Tr. Vol. IV at 810; Szymanski, Tr. Vol. V at 835.)

96. Defendants are failing to provide mental health services for residents who do not display aggressive or disruptive behavior because they only refer for psychiatric evaluation those residents who exhibit such behaviors. (See Szymanski, Tr. Vol. V at 810, 836, 841.)

NURSING SERVICES, INCLUDING PHYSICAL AND NUTRITIONAL MANAGEMENT SERVICES, AT ADC ARE INADEQUATE TO MEET THE HEALTH CARE NEEDS OF RESIDENTS

97. Nursing services at ADC, including physical and nutritional management services, are a substantial departure from accepted judgment, practice or standards, and the lack of these services has contributed to the death of ADC residents and continues to expose residents to serious risk of harm. (Therriault, Tr. Vol. V at 1568-69, 1587, 1589-90, 1620; Therriault rebuttal, Tr. at 2886-90, 2892-97, 2902-03.)

98. Defendants fail to provide a sufficient number of adequately trained nurses to meet the needs of residents. As a result, nurses consistently fail to identify and respond to the health care needs of residents, commit a range of medication errors, fail to adequately monitor the health care problems of

residents, and fail to coordinate health care activities with other institutional professionals. (Therriault, Tr. Vol. V at 1016; Vol. VIII at 1644-47.)

99. ADC nurses do not identify or evaluate residents experiencing acute events such as vomiting, increased respiratory rate or other acute episodes, to determine the etiology of the event or illness. (Therriault, Tr. Vol. VIII at 1591-92, 1596-1606, 1619-20.)

100. ADC nurses do not recognize or react to significant changes in residents' nutritional and medical status. For example, staff often do not respond in a timely manner to significant changes in residents' weight or to resident dehydration. (Therriault, Tr. Vol. VIII at 1576, 1578, 1582-83, 1618-19.)

101. ADC nurses do not routinely perform ongoing monitoring of serious medical conditions, often failing to perform such basic procedures as taking vital signs. (Therriault, Tr. Vol. VIII at 1593-99, 1601, 1695-99; Therriault rebuttal, Tr. at 2891-92.)

102. ADC nurses often fail to respond to crucial information provided by other sources which should alert them to medical problems. As a result, necessary interventions are not undertaken. (Therriault, Tr. Vol. VIII at 1598-99, 1617-19; Therriault rebuttal, Tr. at 2893.)

103. ADC nurses often fail to make themselves aware of the results of medical tests such as laboratory tests, x-rays and other information essential to provide adequate nursing and medical care. (Therriault, Tr. Vol. VIII at 1613-

17.)

104. ADC nurses fail to administer medications in a manner consistent with basic practices, resulting in an unreasonable number of medication errors. (Therriault, Tr. Vol. VIII at 1620-23, 1628, 1630-31, 1641-42; Therriault rebuttal, Tr. at 2886-87.)

105. ADC nurses improperly record medication administration, reporting medications as having been given when in fact they were not, and reporting medication as given before or well after it was supposed to have been given. (Therriault, Tr. Vol. VIII at 1633-40, and rebuttal, Tr. at 2886-87.)

106. ADC nurses are not adequately trained in monitoring drug side-effects. As a result, they often do not recognize toxic reactions or physical symptoms of side effects or of an overdose. (Therriault, Tr. Vol. VIII at 1604-05, 1643-44, and rebuttal, Tr. at 2896-97.)

107. ADC nurses do not act to ensure that residents are protected from unnecessary skin breakdowns. As a consequence, residents unnecessarily develop skin disorders that could have been avoided with appropriate nursing intervention. (Therriault, Tr. Vol. VIII at 1648-51; Therriault rebuttal, Tr. at 2889.)

Physical Therapy (PT) Services are Seriously Deficient

108. Physical therapists with particular experience and expertise with individuals with significant developmental disabilities have been utilized on a consulting basis to provide

training to Arlington's physical therapists in a number of core areas. (Payne, Tr. at 948.) Training for both physical therapists and P.T. technicians in the specialized field of adaptive seating has been provided through the wheelchair clinics held at Arlington by contracted seating specialists. (Payne, Tr. at 956-57.) The physical therapists train direct care staff on body mechanics, transfer techniques, positioning, range of motion, and, with the P.T. technicians, wheelchair positioning. (Payne, Tr. at 959-60, 961-62.)

109. This physical therapy training, however, has been insufficient. Many residents are not properly positioned, provided adequate equipment, including wheelchairs, and provided adequate physical therapy intervention due to lack of a sufficient number of qualified staff. (McEwen, Tr. Vol. VI at 1128-29.)

110. The physical therapy staff at Arlington consists of four full-time registered physical therapists, six full-time physical therapy technicians, and two physical therapist assistant positions. (Ex. 247.)

111. Under ADC's new system for identification of physical therapy needs of the resident, each new admission is evaluated by a registered physical therapist and, if a physical therapy program is determined to be needed, it is developed by a registered physical therapist and formally reviewed annually. Each resident's program is also monitored by their assigned physical therapist on a monthly basis. Whether or not a resident has a physical therapy program, an interim evaluation will be conducted by a physical therapist upon referral by any of the other disciplines who work with that resident. (Payne, Tr. at 912-16.)

112. However, even in light of this recently instituted program, defendants are not providing physical therapy services to all residents who need them, and the services provided are grossly inadequate. (McEwen, Tr. Vol. VI at 1128-29.)

113. Many ADC residents have severe neuromotor impairments, cerebral palsy, and other neuro-muscular deficits. (McEwen, Tr. Vol. VI at 1113.) They require adequate physical therapy services to help them move more easily and efficiently, to help avoid contractures, deformities, acute curvature of the spine due to scoliosis, and to permit them to learn functional skills to enhance their independence. (McEwen, Tr. Vol. VI at 1114-17.)

114. An acceptable physical therapy program must enhance the capacity of the individual to function, i.e., to help him or her to live safely and as independently as possible. Sporadic passive range of motion "therapy" is not sufficient to achieve these goals. Muscles need to be stretched for prolonged periods throughout the day. (McEwen, Tr. Vol. VI at 1118-22.)

115. Defendants are not adequately assessing all ADC residents to determine their need for physical therapy services. (McEwen, Tr. Vol. VI at 1128-29, 1243-44.)

116. PT evaluations, physical management plans, interventions, staffing, staff training, the "school based" physical therapy program and quality assurance are all a substantial departure from accepted professional judgment, practice or standards. (McEwen, Tr. Vol. VI at 1128-30, 1159-63, 1175-80, 1230-34, 1243-46, 1248-53; McEwen, Tr.

Vol. VII at 1268-71.)

117. ADC's failure to provide adequate physical therapy services has precluded residents from developing functional skills, being placed in more "normal" environments, and has caused residents to suffer increased deformities and contractures. Such deformities have posed direct threats to their health. (McEwen, Tr. Vol. VI at 1129-30.)

118. Many of the contractures, deformities, and loss of mobility and other functional skills suffered by ADC residents could have been reduced or avoided if ADC had provided adequate PT and occupational therapy (OT) services to ADC residents. (McEwen, Tr. Vol. VII at 1283-84.)

119. Defendants' failure to adequately assess residents is due, in part, to a lack of sufficient number of trained PT staff to individually evaluate each resident of ADC to determine his or her need for such services. (McEwen, Tr. Vol. VI at 1252-61.)

120. ADC's physical therapy staff lack sufficient expertise to properly evaluate residents for their physical therapy needs, including wheelchair and alternative positioning, intervention programs that promote development of motor skills that will enhance functional independence, and programs that will assist residents in achieving IHP and IEP objectives. (McEwen, Tr. Vol. VI at 1252-61.)

121. ADC's physical therapy is so deficient that passive range of motion and/or passive positioning are the primary interventions provided. (McEwen, Tr. Vol. VI at

1129-30, 1159, 1182.) Overall the emphasis is on maintenance, rather than acquisition of functional motor skills. (McEwen, Tr. Vol. VI at 1179-81.) Such a deficient level of PT services subjects the residents to harm. (McEwen, Tr. Vol. VI at 1129-30.)

122. Defendants do not provide appropriate and necessary adaptive equipment to ADC residents who need such equipment, although the defendants have begun to provide this equipment. (McEwen, Tr. Vol. VI at 1190-91, 1193-94, 1227-28.)

123. ADC does not properly assess and treat acute orthopedic disorders. ADC does not provide needed orthopedic devices, e.g., braces, splints, and body jackets, subjecting residents to unnecessary risks for further deformities and inappropriate body growth. ADC's PTs do not sufficiently refer residents for consultations or other treatments, or follow-up residents who have pain that interferes with proper positioning and motor skills such as standing and walking. These failures lead to loss of skills and increased deformities. (McEwen, Tr. Vol. VI at 1187-88, 1219-20; Hyman, Tr. Vol. IV at 619-23, 632-33, 637-40.)

124. Some ADC residents are placed in wheelchairs that are not designed for their individual needs, e.g., they have sling seats and backs and elevating footrests, or lack essential parts, e.g., footrests. (McEwen, Tr. Vol. VI at 1193-97, 1208-11, 1219, 1225-26.)

125. Many ADC residents are often improperly positioned in wheelchairs or other adaptive equipment. (McEwen, Tr. Vol. VI at 1187-88, 1209-11, 1220-22, 1230,

1235-39.) This improper positioning can cause contractures, deformities and pain, can interfere with eating and digestion, and can even cause asphyxiation. (McEwen, Tr. Vol. VI at 1116-17, 1235; Hyman, Tr. Vol. III at 405.)

126. There are still residents who ADC has identified as needing new wheelchairs who do not have them and others who have not yet been identified by ADC as needing them in spite of obvious deficiencies in their present seating. (McEwen, Tr. Vol. VII at 1227-28.)

127. Residents are often improperly positioned because there are too few staff present to monitor residents or the staff on duty lack the training to position residents properly.
(McEwen, Tr. Vol. VI at 1206-10, 1223-27; McEwen, Tr. Vol. VII at 1312-13.)

128. Occupational therapy services at ADC are also inadequate, in part due to inadequately trained occupational therapy staff. (McEwen, Tr. Vol. VII at 1277-82.)

129. Due to the lack of adequate physical and occupational therapy services, the health of ADC residents has deteriorated. (McEwen, Tr. Vol. VI at 1129-30.)

130. Although the new Director of Therapeutic Services has initiated a revised physical therapy evaluation format (Payne, Tr. at 918-27), the revised assessment procedures are still inadequate and residents continue to lack physical management plans. (McEwen, Tr. Vol. VI at 1169-74, 1230-34, 1243-47.)

131. Notwithstanding Defendants' claims that improvements have been made in physical therapy services, any such improvements have not remedied constitutional deficiencies in PT services. (McEwen, Tr. Vol. VI at 1129-30, 1233-34, 1248-53.)

EDUCATION SERVICES TO SCHOOL-AGE CHILDREN FAIL TO MEET THE REQUIREMENTS OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

132. Of the 56 school age Arlington (ADC) residents, 49 presently receive their education on the ADC campus. The number of school age residents is expected to drop to 48 and the total ADC student body will number 34. (Hansen, Tr. at 2195-97.)

133. The Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400, et seq., assures all handicapped children of a "free appropriate public education." 20 U.S.C. §§ 1400(c) .

134. Arlington's educational program is carried on in five classrooms - two in the "school area" with an additional room for music, and three in the Baker Building for more physically involved students. (Hansen, Tr. at 2200-02.)

135. Four certified special education teachers are on the Arlington staff. A certified substitute is also currently on the staff, along with 12 teacher assistants, numerous foster grandparents, a principal who oversees the program and an educational consultant. (Hansen, Tr. at 2197-2200.)

136. Teachers receive in-service and on-the-job training in numerous areas. (Hansen, Tr. at 2213-15.)

137. Defendants, however, are failing to provide special education and related services sufficient to meet the unique needs of the school-age children at ADC (Thibadeau, Tr. Vol. VII at 1513-15; Vol. VIII at 1527-28.) Further, educational services are not being provided in the least restrictive environment. (Thibadeau, Tr. Vol. VIII at 1523-24.)

138. Individualized Education Plans (IEPs) developed at ADC are inadequate because, inter alia, ADC's assessments of children are incomplete and inappropriate. (Thibadeau, Tr. Vol. VII at 1472-75.)

139. ADC's assessments of children fail to contain an adequate statement of the students' present level of performance or sufficiently describe the abilities and needs of students. (Thibadeau, Tr. Vol. VII at 1474-75.)

140. ADC does not provide sufficiently comprehensive training objectives in their IEPs to meet students' needs. IEPs do not seek to promote the development of new skills. (Thibadeau, Tr. Vol. VII at 1474-87.)

141. The skills identified as goals for many students in IEPs are not functional, i.e., the skill to be learned bears little relationship to activities of daily living. (Thibadeau, Tr. Vol. VII at 1477-79.)

142. The goals identified in the IEPs are often not related to one another and are often unduly repetitious.

(Thibadeau, Tr. Vol. VII at 1479-87.)

143. ADC does not take steps to ensure that skills learned in the classroom are maintained or generalized to non-classroom settings. (Thibadeau, Tr. Vol. VII at 1502-04.)

144. ADC has not consistently developed goals in IEPs for the requisite one year period and multiple goals are written for the same skill. (Thibadeau, Tr. Vol. VII at 1487-89.) Goals written for students are too narrow, too limited in their scope and tend to assume children lack the capacity to grow, learn and develop. (Thibadeau, Tr. Vol. VII at 1478-87.)

145. ADC does not have an adequate recordkeeping system in place to appropriately monitor the educational status of students. (Thibadeau, Tr. Vol. VII at 1489-92, 1494-501.)

146. Teaching staff at ADC do not provide adequate and appropriate interactions with students. (Thibadeau, Tr. Vol. VII at 1504, 1508-10.)

147. Related services, including, but not limited to, physical therapy, behavioral training, and speech and language services provided by ADC are inadequate to allow children to benefit from special education services as required by the IDEA. (Thibadeau, Tr. Vol. VII at 1513-16; Vol. VIII at 1523.)

148. Although recent steps have been taken to provide children with educational services within the Shelby County Public School system, school-aged children remain at ADC who could more appropriately benefit from receiving

educational services outside ADC and are therefore not being educated in the least restrictive environment as required by the IDEA. (Thibadeau, Tr. Vol. VIII at 1523-26.) In addition, transitional services designed to facilitate students' integration into post school-age settings are inadequate. (Thibadeau, Tr. Vol. VIII at 1523-26, 1528.)

149. Notwithstanding Defendants' claims that improvements have recently been made in educational services, any such improvements have not remedied deficiencies in ADC's educational program. (Thibadeau, Tr. Vol. VIII 1524-26.)

DEFENDANTS HAVE NOT INITIATED REMEDIAL ACTION TO CORRECT IDENTIFIED DEFICIENCIES

150. The Defendants failed to begin remedial measures, even on life-threatening issues, until after the actual filing of a lawsuit in this case, even though state officials were informed as early as July 1990 that life-threatening conditions existed at ADC. In fact, some efforts undertaken by defendants did not occur until after the United States filed for a preliminary injunction in March of 1993. (See Hyman, Tr. Vol. IV at 650-651.)

151. ADC has demonstrated resistance and indifference to corrective action. Testimony of former employees and parents of residents indicated that many staff do not know residents or their needs, do not speak to them, hug the children, or even sit on their furniture. There was substantial evidence that employees who entered the institution with the best of intentions were repeatedly rebuked

when they tried to implement necessary, basic, and fundamental improvements. Indeed, various employees failed to cooperate with former employees' legitimate requests for cooperation and implementation of programs, even in life-threatening situations. Parents likewise repeatedly testified that institutional officials failed to cooperate with their reasonable requests for assistance, including requests for services, investigations into alleged abuse, and even basic information about their children. (Nuckolls, Tr. Vol. VI at 1057, 1059-64, 1066-68, 1070-71; Davis, Tr. Vol. IX 1788-1793; Tucker, Tr. Vol. IX 1820-25, 1828-1831; Rol. Palmer, Tr. Vol. VII at 1354-56, Ex. 89, and generally.)

152. There have been unexplained and suspicious irregularities in employee statements to the United States' experts and in records provided by the Defendants, such as claims by staff to have been trained when not so trained, data obviously documented long after the event recorded occurred, documentation showing data taken when in fact it was not, and obviously unauthorized and/or forged signatures on documents. (Hyman, Tr. Vol. III at 410-412; Therriault, Tr. Vol. V at 1029-1039; Therriault, Tr. Vol. VIII at 1632-37, 1639-40; Thibadeau, Tr. Vol. VII at 1497-1502; Reb. Palmer Test.).

152. In the past and during a number of recent DOJ tours, ADC put on a "show" and/or visits were staged for the experts or others touring. (Christian rebuttal, Tr. at 2765-69; Rol. Palmer, Tr. Vol. VII at 1366-67.)

153. Defendants fail to monitor resident property to protect it from theft and many ADC residents have lost unreasonable amounts of personal property. (See Derringer,

Tr. Vol. IX at 1873.)

ENTERED this 17 day of February, 1994.

/s/_____
JON PHIPPS McCALLA
UNITED STATES DISTRICT JUDGE

APPENDIX N

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

FILED
September 2, 1994
JON P. McCALLA

UNITED STATES OF AMERICA, Plaintiff,	)	Civil Action
	)	No. 92-2062-ML/A
v.	)	
	)	
STATE OF TENNESSEE, et al., Defendants.	)	
	)	

REMEDIAL ORDER

ORDER

Defendants are hereby Ordered to take the following actions to guarantee the statutory and constitutional rights of residents of Arlington Developmental Center (ADC). Defendants shall remedy the constitutional and statutory deficiencies identified in the Supplemental Findings of February 18, 1994.

I. PROTECTION FROM HARM

Defendants shall provide a safe and humane environment at ADC and protect residents from abuse, mistreatment and neglect. Defendants shall immediately act to properly supervise residents of ADC and otherwise protect them from harm. To this end, and at a minimum, Defendants shall:

A. Immediately provide 1:1 staffing to residents exhibiting the most severe self-injurious or aggressive behaviors, and any other resident who is determined by the Chief Psychologist, the interdisciplinary team or a physician to require such staffing to ensure safety. Staff providing 1:1 coverage shall be specially trained in the appropriate behavior management and teaching techniques applicable to the resident for whom they are providing the 1:1 coverage.

B. Provide adequately trained and supervised direct care staff to meet a 1:4 (day), 1:4 (evening) and 1:8 (night) staff-to-client ratio. This ratio shall be calculated by counting only staff actually present at ADC. Staff engaged in housekeeping or other chores may not be counted to meet the staffing ratio. Furthermore, staff assigned to 1:1 interaction

with a particular resident may not be included .in meeting the staffing ratio for the other residents in the area.

C. Prepare a monthly injury report that describes type of injury, resident(s) involved, location, shifts and staff present or on duty for the purpose of identifying factors leading to such injuries. All reports, including recommendations to reduce the incidence of injury, shall be reviewed by the Abuse and Neglect Prevention Committee and the Behavior Management Committee.

D. Defendants shall ensure ADC residents are protected from abuse, neglect, and preventable injuries; unnecessary restraint and restrictive procedures, and unnecessary medication through, prevention, reporting, investigating and resolution techniques. Prevention includes elements of staff training and supervision. Systematic review of information about abuse, neglect and injuries shall occur in order to eliminate the conditions and practices that contribute to the occurrence of such incidents. The Defendants shall accomplish this in the following ways:

1. The Defendants will hire two full-time investigators who will report directly to the Assistant Commissioner for Mental Retardation Services and who will be assigned to ADC to investigate abuse, mistreatment, and neglect, including injuries for which the investigator has suspicion of abuse, mistreatment, or neglect and all injuries of an unknown cause. The number of investigators may be adjusted with the approval of the Monitor.

2. Qualifications of Investigators will include:

a. Professional training and experience in conducting investigations.

b. Demonstrated skill in investigation techniques and in interviewing.

c. Training on conducting investigations in institutions serving developmentally disabled persons. Such training may be obtained after hiring but before assigned a case to investigate.

3. Responsibilities of Investigators will include:

a. Publish prominently his or her name, phone number, and current photograph in all residential, program, and office areas and distribute the written materials to all staff, parents or guardians, and consumers.

b. Receive all allegations of abuse, mistreatment, and neglect and perform a preliminary investigation to determine whether an allegation is founded or unfounded.

c. Report in writing all allegations of abuse, mistreatment, or neglect and the Investigator's determination that the allegation was founded or unfounded to the Abuse and Neglect Prevention Committee and the Superintendent.

d. Investigate fully all allegations of abuse, mistreatment, and neglect determined to have foundation and prepare a detailed, written report of the investigation and its findings, specifying whether or not abuse, mistreatment, or neglect has been confirmed and whether or not the perpetrator has been identified.

e. Provide the reports of all investigations to the chairperson of the Abuse and Neglect Prevention Committee and appear before the committee to present the evidence of the investigation and answer the committee's questions.

f. Investigate all suspicious injuries and injuries of unknown cause to determine if possible abuse, mistreatment, or neglect has occurred and if so, treat the injury as an allegation of abuse, mistreatment, or neglect.

g. Track repeated incidents of confirmed abuse, mistreatment, or neglect of an individual resident and meet with the resident's Interdisciplinary Program Coordinator (IPC) following any second incident with respect to a resident and each succeeding incident within a one year time period.

h. Track the time., location, and staff present for all injuries and all confirmed abuse, mistreatment, or neglect when perpetrator is unknown. The investigator will analyze this information for trends and when trends emerge, report such information to Department of Mental Health and Retardation (DMHMR) and the Superintendent. Defendants will take appropriate action as a result of the information provided.

i. Make recommendations to IPCs and the safety officer of any measures designed to reduce abuse, neglect, or injuries.

j. Train all staff on reporting allegations of abuse, mistreatment, and neglect and on preserving evidence.

k. Maintain confidentiality concerning information

relating to all allegations and investigations, except to the extent mandated by the operation of state law.

4. An Abuse and Neglect Prevention Committee will be formed at ADC.

5. The Abuse and Neglect Prevention Committee will be composed of sufficient numbers of staff to ensure the attendance of at least five members at all meetings, three of whom will be ADC staff and at least one of whom will not be employed by ADC or DMHMR. Members of the committee will include the Consumer Advocate, an ADC Trustee, staff with no history of abuse or neglect, and members of the community. The chairperson (or alternate chairpersons if required) of the committee will be elected by the committee from among the ADC staff serving on the committee. Any ADC staff directly involved in a case will not be a member of the committee hearing that case.

E. All direct care staff will be trained to appropriately supervise residents in order to reduce abuse, neglect and mistreatment. All direct care staff will be trained to recognize and report abuse, neglect and mistreatment.

II. STAFFING

Defendants shall ensure that a sufficient number of nurses, physicians, psychologists, registered physical therapists and other staff are employed to fulfill the requirements of this Order. To this end, and at a minimum, Defendants shall:

A. Employ a sufficient number of registered and

licensed practical nurses to provide adequate nursing services to residents.

B. Defendants must retain a Chief Psychologist who meets the qualifications set forth in this section and who is capable of performing the responsibilities listed herein.

1. Qualifications of Chief Psychologist

a. A Ph.D. in psychology specializing in applied behavioral psychology.

b. Experience assessing the behavior treatment needs, including functional analysis, of developmentally disabled persons with severe maladaptive behavior; developing, implementing, and evaluating Individual Behavior Treatment Programs (BTPs) for such individuals; and supervising other psychologists in these professional practices.

C. Hire or retain the services of Masters level psychologists sufficient to provide adequate psychology services to all residents.

D. Provide sufficient psychiatrists to provide adequate and appropriate psychiatric services to all residents who need such services.

E. Retain the services of a physiatrist to provide adequate physiatric services to all residents who need such services.

F. Retain the services of an orthopedist to provide adequate orthopedic services to all residents who need such services.

G. All staff training required by this Order shall be conducted by individuals with demonstrated expertise in the particular field, documented both as to time, duration, attendance and results, and all training, unless for good cause, shall be task-analyzed and competency-based. Defendants shall record each training session and identify employees trained. All new employees shall be provided appropriate training in a timely manner.

III. PSYCHOLOGY AND HABILITATION

Defendants shall provide adequate and appropriate psychology and habilitation services for ADC residents. Defendants shall develop for each resident an individualized training program designed by competent and qualified professionals to: 1) develop or maintain his or her functional skills, including skills in the areas of communication, self-help, safety and daily living; and 2) reduce or eliminate unreasonable risks to personal safety or unreasonable use of bodily restraints. In order to fulfill this requirement, Defendants shall, at a minimum:

A. Have qualified professionals conduct an evaluation and assessment, including functional analysis, of each resident exhibiting maladaptive behavior, including self-injurious, aggressive, and/or pica behaviors, to determine his or her individual need for training to reduce or eliminate those behaviors.

B. Have qualified professionals conduct an evaluation and assessment, including functional analysis, of each resident to determine his or her individual need for training to develop new, adaptive skills, including self-care skills.

C. Develop and implement a training program for each resident. Each training program shall contain, at a minimum:

1. Objectives developed by an appropriately constituted interdisciplinary team (IDT) that are based upon appropriate assessments and evaluations and contain professionally based objectives both to reduce inappropriate behaviors and develop new skills;

2. Specific instructions for those responsible for implementing the training program; such methods shall emphasize positive approaches and positive behavioral interventions which promote functional skill development and socially acceptable behaviors in the resident;

3. A specific training schedule to be followed, with sufficient hours of training to permit the resident to have a reasonable opportunity to reach the identified training objectives; scheduled activities shall take place on weekends as well as weekdays;

4. Data collection procedures sufficient to permit a qualified professional to evaluate the effectiveness of the training program, to monitor the implementation of the training program and enable its modification, as

necessary; and,

5. Identity of persons responsible for the implementation of the program.

D. Within 30 days of the development of the programs referenced above, ensure that staff are trained to implement the training program of each resident under their care, including knowledge of program objectives and responses *to* maladaptive behaviors.

E. Fully implement all training programs.

F. Require a qualified professional to supervise implementation of training programs, including having line authority over direct care staff involved in any type of training or programs.

G. Implement procedures to assess and evaluate each resident's progress on behavior and training programs, including the collection of reliable data on the target behaviors.

H. Train all direct care staff in collecting and maintaining relevant data and provide training periodically thereafter to maintain data collection skills. Ensure that all direct care staff are trained in the skills necessary to perform the tasks required to provide adequate and appropriate psychology and habilitation services.

I. Develop procedures to review the progress of each resident at least quarterly in order to ascertain the adequacy and effectiveness of the training programs. Review

of residents' progress under a training program that includes a reduction component to reduce aggressive or dangerous behaviors must occur at least monthly or more frequently in the case of severe self-injury or aggression, in order to ascertain the adequacy and effectiveness of the behavior programs. Programs found upon review to require modification must be modified.

J. Retain expert consultant assistance necessary to comply with paragraphs III.A to III.I in order to carry out the tasks identified above.

K. The Chief Psychologist will have at least the following responsibilities:

1. Oversight of Individual BTPs: (1) ensure compliance with relevant ADC policies and procedures; (2) conduct quarterly peer reviews based on these policies and procedures with the assistance of a non-ADC psychologist whose qualifications are similar to or complement those of the Chief; (3) conduct regular meetings with staff psychologists to review critical cases; (4) chair the Behavior Management Committee which will review and approve programs recommending the use of restraints and other intrusive procedures; (5) review monthly Risk Management Reports for the use of emergency physical and chemical restraints; and (6) review reports of confirmed abuse, mistreatment, and neglect and injury reports to determine the need for additional behavioral interventions for residents who are subjects of these reports.

2. Training of Staff Psychologists: (a) inservice Staff psychologists on the Individual BTP policies and procedures; (b) provide technical assistance and consultation on an individual basis with respect to assessment of individual resident's needs, development of Individual BTPs, and evaluation of the effectiveness of Individual BTPs.

3. Employment of Staff Psychologists: (a) approve the hiring and retention of staff psychologists; and (b) evaluate semiannually the work of each staff psychologist based on the quality and effectiveness of the Individual BTPs developed by the staff psychologist.

4. Review weekly all serious injury and abuse reports for residents who are on Individual BTPs. For each incident, confer with a resident's staff psychologist to determine if modifications of Individual BTPs or additional staff training could reduce serious injuries or abuse of the resident. If further staff training is indicated, notify the Assistant Superintendent for Residential Services.

5. Review staff psychologists' reports of problems with other staff member's implementation of the BTP and data collection and discuss these with the appropriate Program Director. If these problems are not resolved within one month, report them and the lack of their resolution to the Assistant Superintendent for Residential Services.

6. Notify the Superintendent in writing of any

problems that limit the effectiveness of Individual BTPs, including problems related to cooperation, implementation, and both staff and material resources.

L. The Behavior .Management Committee (BMC), including a primary care physician, shall meet to review those aspects of each resident's training program relating to the resident's maladaptive behavior(s) and relevant progress notes for each resident:

1. who exhibits self-injurious behavior or causes injury to self or others through aggressive behavior and whose training program includes bodily restraint or psychotropic medication, or

2. for whom bodily restraint procedures are utilized three or more times within any six-month period, or who receives psychotropic modifying medication.

M. Where a resident suffers a serious or significant self-inflicted injury or inflicts a serious or significant injury on another resident, the psychologist assigned to the resident shall conduct an immediate review of such behavior(s) and report the results of such review to the BMC. In all reviews conducted by the BMC pursuant to this paragraph, the BMC shall ascertain whether (a) there is sufficient behavioral data recorded, (b) such data are reliable, and (c) the continuation of the current training or treatment program is justified, or the program, including medication, should be modified. Where inadequate or unreliable data are found, or the continuation of the training or treatment program is otherwise not justified, the matter shall be referred to the appropriate IDT which

shall, within 30 days from the referral, modify the existing training program in accordance with the judgment of qualified professionals, including the primary care physician, psychologist and psychiatrist, as appropriate. The BMC shall meet at least every three months during the first year of this Order and at least semi-annually thereafter. The BMC and ADC's Human Rights Committee (HRC) shall be reconstituted in a manner sufficient to meet the requirements of this Order.

IV. RESTRAINT

Defendants shall ensure that unnecessary or inappropriate restraints are not used at ADC. To this end, and at a minimum:

A. Every behavior program that utilizes restraint or time out must specify:

1. the behavior that initiates the use of the restraint or time out;

2. behaviors to be taught to the resident to replace the behavior that initiates the use of the restraint or time out or other program to reduce or eliminate the use of the bodily restraint or time out;

3. the restriction, i.e., restraint or time out authorized, including the restriction's duration;

4. the professional responsible for the program and the direct care workers authorized to implement it; and,

5. the frequency with which behavioral data is to be recorded by direct care workers.

B. Defendants shall, in order for a restrictive procedure to be included in a behavior treatment program, document in the resident's record that other, less restrictive techniques were systematically employed as part of a professionally designed training program and were ineffective.

C. Defendants shall document each time restraints or time out is used and the length of time for each use. The BMC shall conduct a monthly review of each use of restraint and each use of time out. The Human Rights Committee shall also review restraint usage on a regular basis. Each committee shall make recommendations with respect to the appropriateness of the use and continued use of the restraint, which recommendation shall be promptly implemented.

V. PSYCHIATRY AND THE USE OF DRUGS

Defendants shall provide adequate and appropriate psychiatric and mental health services to residents who need such services and ensure that the use of psychotropic drugs is appropriate. Medication shall not be administered as punishment, in lieu of a training program, or for the convenience of staff. To this end, Defendants shall, at a minimum:

A. Appropriately prescribe and administer medications for residents.

B. Initiate and implement a system which requires

that every behavior program that utilizes psychotropic[1] medication specifies:

(1) the behavior that initiates the use of the psychotropic medication; and

(2) the behaviors to be taught to the resident to replace the behavior that initiates the use of the medication or other program to reduce or eliminate the use of the medication.

C. Document that, prior to using the psychotropic medication, other, less restrictive techniques have been systematically tried as part of a training program and have been demonstrated to be ineffective. Such documentation in the resident's record must include reliable behavioral data collected on the resident.

D. Administer prescription medication only upon order of a physician and psychotropic medication only upon order of a physician after consultation with a psychiatrist, except in case of an emergency use of psychotropic medication, which must be reviewed within 24 hours of the order being written. The psychiatric consult shall be obtained to determine whether the use of any medication is supported by a diagnosis of mental illness (or other medical reason), that the diagnosis is justified by the resident's history as set forth in his/her written record and current symptoms and that the

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[1] As used here, psychotropic medication also includes any medication of other classes that is used specifically for the purpose of altering a resident's behavior.

dosage is appropriate. In making this determination, the consulting psychiatrist shall make a complete assessment of the resident, including observation of the resident, examination of the resident's medical and behavioral record, and consultation with the resident's primary care physician, psychologist and other IDT members, including direct care staff.

E. 1. Establish and implement procedures to review the drug regimen of each resident every 30 days;

2. Have a physician note in the record of each resident receiving psychotropic medication the mental illness diagnosis for which the medication is prescribed and the dosage level:

3. Evaluate each resident receiving psychotropic medication for drug-induced side effects, at professionally determined intervals;

4. Permit to administer medication only those staff qualified under State law to do so;

5. Record in each resident's record and report separately to appropriate professional staff any medication error or adverse drug reaction;

6. Ensure that all residents with seizures are prescribed the fewest number of different medications appropriate for effective seizure management.

F. Require a psychiatrist to serve on the IDT of any resident whose individual plan of service includes the use

of psychotropic medication or for whom such has been recommended. In addition, a psychiatrist or other mental health professional should serve on the IDT of any individual who receives, or is recommended to receive, other mental health services.

G. Train all clinical and direct care staff to recognize signs of mental illness in order to refer residents for psychiatric consultation.

VI. MEDICAL CARE

Defendants shall provide ADC residents with adequate and appropriate medical care, including adequate medical specialty services. To that end, and at a minimum, Defendants shall:

A. Retain the services of a Developmental Medicine Physician. The role of this physician need not be limited to responsibilities at ADC, but for a period of two years, at least approximately 75% of this physician's time will be devoted to ADC. This physician will have the following responsibilities:

1. Exercise clinical supervision of the ADC physicians.

2. Participate in the selection, evaluation, and retention of medical specialists and other physicians.

3. Chair the Physician Peer Reviews and serve on the Mortality Review Committee and participate in the Nursing Peer Reviews. In the interim, if the

Developmental Medicine Physician is a consultant, he or she will co-chair the Physician Peer Reviews and serve on the Mortality Review Committee with the Medical Director.

4. Provide on-going in-service and individual consultation to the ADC physicians and consultation to medical specialists.

5. Evaluate, with the Medical Director, semi-annually each primary care physician based on the adequacy and appropriateness of health care provided to ADC residents.

6. Serve as a consultant to the Clinical Nutritional Management Teams and other therapists.

B. Require primary care physicians to be responsible for and oversee the provision of health care for the residents for whom they are responsible. Primary care physicians shall, in a timely manner:

1. Evaluate each resident for whom they are responsible;

2. Determine what specialized medical services these residents need and ensure that residents receive such services;

3. Take appropriate action to respond to recommendations of outside medical specialists and laboratory findings, documenting what action has been taken and the reasons therefor.

C. Under the supervision of the Developmental Medicine Physician, primary care physicians will be responsible for and oversee the provision of adequate and appropriate health care to all residents assigned to them.

1. For all residents, the primary care physician will develop a comprehensive problem list and an annual medical plan for each resident and will participate actively in the prevention of health risks to residents, including, but not limited to, the prevention of injury and abuse.

2. For persons with special needs, the primary care physicians will:

(a) Provide appropriate medical management for residents with feeding disorders, and work cooperatively with the Clinical Nutritional Management Teams and appropriate medical and dysphagia specialists to ensure that residents are fed safely and properly, obtain needed medical and/or surgical interventions, and receive adequate nutrition and hydration.

(b) Provide appropriate medical management, including timely and appropriate interventions or referrals, for residents with acute and chronic orthopedic disorders, and work cooperatively with physical and occupational therapists to prevent residents from suffering unnecessary pain, disfigurement, or loss of mobility and function.

(c) Provide appropriate medical management for

residents with seizure disorders, and work cooperatively with neurology consultants to ensure the residents receive treatment that is therapeutic, safe, and effective.

(d) Provide appropriate medical management for residents who have behavior disorders or who are receiving psychotropic medications; and work cooperatively with staff and consulting psychologists, psychiatrists, and mental health counselors to ensure residents receive appropriate and effective treatment services.

(e) Provide adequate emergency medical care, working cooperatively with medical and non-medical staff to ensure that the living units they are assigned to are adequately staffed with individuals trained in emergency response and that the units are adequately equipped with necessary emergency equipment.

(f) Participate in the process of outplacement for any residents for whom they are the attending physician, including assessing the medical strengths and weaknesses of the resident being considered for outplacement, analyzing the medical resources that the resident may require in the community, and assisting in the determination of the appropriateness of the community setting chosen for the resident.

(g) Ensure that all mechanical restraints are safe and medically appropriate for the individuals on whom they are used.

D. Under the supervision of the Medical Director and the Developmental Medicine Physician, ADC physicians will regularly review all residents for their need for evaluation, consultation, and treatment by medical specialty consultants, including board certified neurologists, orthopedists, gastroenterologists, psychiatrists, ophthalmologists, otorhinolaryngologists, physiatrists, and gynecologists, and record the outcome of this review in the residents' records. Defendants will ensure that medical specialists provide adequate and appropriate medical care. The requirement that specialists be board certified may be waived by the Monitor on an individual basis and is hereby waived for board eligible consultants serving under the contract with the University of Tennessee.

E. Each resident's primary physician will ensure that needed medical specialist consultations are obtained in a timely manner and will follow-up on specialists' recommendations including monitoring blood tests and other necessary lab work and will document the reasons for not following specialists' recommendations when this occurs.

F. ADC medical staff will provide adequate and appropriate medical care for seizure disorders, including appropriate evaluation, management and treatment. Toward this end, Defendants will ensure that the following actions are taken:

1. The consulting neurologist(s) retained by ADC will complete the process of examining and evaluating all residents who receive anticonvulsant medication to assure correctness of diagnosis and efficacy of treatment. Thereafter, the frequency of follow-up will

be determined by the medical judgment, of the consulting neurologist(s). Residents receiving two or more anticonvulsant medications, or residents who have had five or more seizures in the preceding 12-month period will be examined by a consulting neurologist at least annually.

2. ADC primary care physicians will refer residents for neurology consults when appropriate. The results of the consultant's findings and recommendations will be maintained in the resident's medical record. The primary care physician must review and respond to all recommendations by the neurology consultant. If the primary care physician determines that the consultant's recommendation will not be followed, valid clinical justification for that determination must be documented in the resident's medical record.

3. Anticonvulsant medication levels will be used to guide therapy, in conjunction with clinical judgment. Levels will be monitored at professionally appropriate time intervals during initiation or change in therapy. Once a therapeutic dose is established, anticonvulsant medication levels will be routinely monitored at least every six months. Levels will be monitored at other times as clinically indicated. Therapeutic drug monitoring and physician follow-up of anticonvulsant medication blood levels will be monitored by a quality assurance process.

4. If a resident is to be maintained on sub-therapeutic or potentially toxic levels of anticonvulsant

medication, that therapy will be in consultation with a neurologist and justification will be documented in the resident's record. A review by the consulting neurologist(s) of residents in these categories will be performed and the frequency of follow-up will be determined by the consulting neurologist.

5. In the process of attempting to achieve monotherapy, if the resident suffers an increase in the number of seizures despite adequate blood levels of the primary anticonvulsant medication, referral to the consulting neurologist(s) will be made.

6. Residents who have been seizure free for two years or more will be assessed, in consultation with a neurologist, as to the appropriateness of medication withdrawal. The decision as to the appropriateness of medication withdrawal, as well as any withdrawal plan, will be documented in the resident's medical record.

7. ADC will immediately cease administering medications by the intra-muscular (IM) route for residents in status epilepticus. Residents in status epilepticus shall be immediately transported by ambulance to emergency care at an acute care hospital Anticonvulsant medications will be administered to residents in status epilepticus via intra-venous (IV) or rectal routes only. Residents who are potentially at risk for status epilepticus or to periodic prolonged series of seizures will be identified, and a plan developed by the primary care physician and neurologist which sets out planned or recommended

treatment for that individual if status or a series of seizures occur.

8. Track seizures by accurately recording each seizure. All staff, including nursing and direct care, shall be trained in how to recognize a seizure, describe the type of seizure and length of time it lasts and record that information in the resident's record. Defendants shall implement a quality assurance process to ensure that all seizures are being appropriately documented.

9. Staff physician performance in seizure management will be reviewed in the Physician Peer Review process and will also be monitored by a quality assurance process implemented by ADC nursing staff. This monitoring process involves a review, at specified intervals, of a percentage of the charts of residents receiving anticonvulsant medications. The criteria monitored include type and number of anticonvulsant medications, level of seizure activity, timeliness of laboratory tests, physician response to abnormal lab results, physician follow-up of neurology consultant recommendations, and need for neurology consultation. Findings of this monitoring shall be reported to the ADC Medical Director for appropriate responsive action.

G. Train all staff physicians, registered nurses (Rns), licensed practical nurses (LPNs), Development Technician Trainers (DTTs) and Developmental Technicians (DTs) who regularly provide direct care services at ADC with training in emergency procedures, including the proper way

to administer cardio-pulmonary resuscitation. Thereafter, Defendants shall evaluate, through the use of drills, the competence of all participating staff to perform emergency medical procedures, document such evaluations and provide such additional training as the evaluations indicate is necessary to ensure staff competence in emergency procedures. Further, Defendants shall make medication and equipment commonly used in emergencies readily available to qualified staff in each residential unit.

H. The Defendants will develop and negotiate agreements with hospitals serving ADC residents to require the timely transfer of records to and from acute care hospitals as follows:

1. When residents are admitted to acute care hospitals or other treatment facilities outside of ADC, adequate and appropriate records are to accompany the residents including, but not limited to the following: referral for emergency care or hospital admission; physician progress notes; active and inactive problem lists; authorization for treatment; and physician's orders of the last 90 days, including current medication orders.

2. When residents are discharged from an acute care hospital for readmission to ADC, at a minimum, the following information will accompany the resident: the diagnosis and treatment recommendations for ADC to follow. ADO physicians or nurses will document telephone orders made by acute care hospital physicians.

3. When residents are discharged from acute care hospitals or other outside treatment facilities, ADC will receive, in a. timely manner, hospital records including, but not limited, to the following: diagnosis and course of treatment; physician's progress notes; discharge summary; plan for follow-up; and pertinent laboratory findings, diagnostic evaluation reports; and consultation reports. ADC physicians will obtain by phone and document in the residents' record relevant information about the resident's hospital stay while awaiting receipt of these hospital records.

4. For residents who were admitted to hospitals or other outside facilities while these agreements are being negotiated, ADC will obtain from these facilities a record of the hospital stay including diagnosis, course of treatment, and discharge summary. ADC will make a concerted effort to obtain hospital records for those residents hospitalized within the past two years.

I. Ensure that ADC physicians appropriately prescribe medications and monitor blood levels and drug side-effects.

J. Ensure that diagnoses and treatment for acute orthopedic trauma, as well as for chronic and progressive orthopedic disorders, are timely.

K. Ensure that the primary care physicians diagnose fractures in a timely fashion.

L. Ensure that peer reviews and mortality reviews

are thorough and that ADC staff respond to identified deficiencies. Peer review documents may only. be reviewed by the Monitor.

VII. PHYSICAL AND NUTRITIONAL MANAGEMENT

Defendants shall ensure that all residents at ADC who are nutritionally at risk due to associated physical handicaps or medical problems are fed and otherwise cared for safely, adequately and appropriately. To this end, and at a minimum, Defendants shall:

A. Cease dangerous feeding practices and any feeding practice that poses an undue risk of harm to any resident.

B. Cease feeding residents in any unsafe position or faster than they can safely chew and swallow food.

C. Ensure that all residents' bodies are in proper alignment while they are being fed and for appropriate periods of time after they have been fed. Cease the practice of putting residents to bed or flat on their backs immediately after being fed. No resident shall be put to bed after being fed until sufficient time has passed to allow digestion of food.

D. Provide residents with all appropriate adaptive feeding equipment.

E. Require staff to feed residents either seated beside or next to the resident and not while standing, unless the resident's individual feeding plan specifically requires otherwise.

F. Utilizing postural drainage only when performed by a qualified respiratory therapist.

G. ADC will utilize a Nutritional Management Advisory Committee to oversee the implementation of the Feeding Program. This committee will include the administrators of the Swallowing/ Dysphagia program, Therapy Services, Dietary, Medical Services, Nursing, Psychology, and a representative from each Clinical Nutritional Management Team, and where appropriate, external consultants. This committee will develop and oversee implementation of policies and practices designed to meet safely the nutritional management needs of the residents. The committee will assist in and support the delivery of services in accordance with general nutritional management principles and resident-specific nutritional management plans.

H. Each resident of ADC will be assessed on an annual basis, with the exception of those residents who have already been identified as having feeding or nutritional problems and who will be assessed and evaluated as soon as the Clinical Nutritional Management Teams have been established. For the general resident population, this assessment will include, at a
minimum, a chart review that indicates a history of illness, weight gain or loss, medications ~ and potential food and drug interactions; review of current eating skills and/or behaviors, assessment for appropriate adaptive equipment, and a review of positioning during mealtimes. This assessment will be conducted' under the direction of an assigned swallowing therapist who may be a licensed speech/language pathologist, occupational therapist, physical therapist, or nurse and who has had training in the

management of feeding and nutrition problems of persons who are developmentally disabled. For those residents already identified with feeding or nutritional problems, referral to the Clinical Nutritional Management teams will be made for the purpose of providing an adequate comprehensive evaluation or determining that an adequate comprehensive evaluation has been performed.

I. Based on the assessment, an individualized dining plan will be written for each resident. Staff who feed the resident or supervise the resident during mealtimes will be trained on the feeding or mealtime techniques or procedures called for in the dining plan. These staff will be monitored during mealtimes to determine that the individualized dining plan is implemented as designed.

J. Defendants will establish one Nutritional Management Clinical Team at ADC for every 25 residents requiring nutritional management. In the future, the number of residents served by a Nutritional Management Clinical Team may be adjusted with the approval of the Monitor. Each team will develop the special expertise needed to provide nutritional management services to residents who have feeding or nutritional problems, who require. feeding by other persons, or who have behavior problems that interfere with mealtime. Each team will have direct clinical responsibilities for up to 25 residents who are highest risk for injury, illness, or loss of function related to feeding or nutritional problems.

1. Composition of each Nutritional Management Clinical Team: Each team, as a whole, will include the following: a physical therapist, an occupational therapist, a registered dietician, a nurse, and a

physician. At least one team member will be a feeding specialist who has advanced training in the management of feeding and nutrition problems of persons who are developmentally disabled. This specialist may be a speech therapist who will serve in addition to the physical and occupational therapist on the team.

2. Clinical Team training: the teams will receive initial training from professionals with recognized expertise in evaluation and treatment of developmentally disabled persons with feeding and nutritional problems. Also, Clinical Team members will be engaged in continuing education activities that enhance their expertise in nutritional management.

3. Time commitments of Clinical Team members: members of each Clinical Team will be assigned to the team on a full-time basis except for the physician and dietician members of the Teams who will be assigned to the Team a minimum of 10 hours per week. The Developmental Medicine Physician will serve as a consultant to the Clinical Teams.

K. The therapists on the Clinical Nutritional Management Teams will serve on the Inter-Disciplinary Teams for those residents assigned to their team and will provide needed therapy services to these residents but will not serve residents who are not assigned to their Clinical Team, except in circumstances of occasional individual consultation or treatment.

L. Responsibilities of the Clinical Teams:

1. Continue to screen all residents as necessary to determine their need for nutritional management by observing mealtimes and interviewing staff, including nursing staff;

2. Perform a comprehensive evaluation, or ensure that a comprehensive evaluation has already been performed, of residents identified as possibly having feeding, nutrition, or related problems. Refer residents, as appropriate, for specialty consultations, examinations, and evaluations.

3. Review evaluations by the Clinical Team and specialists to determine which residents need nutritional management services by the Team.

(a) For residents who do not require the services of the clinical team, individualized dining plans will be developed and implemented according to **¶ B.3.**

(b) Residents needing nutritional management services as part of the case load of a Clinical Nutritional Management Team will be those individuals who are determined to be at risk for injury, illness, or loss of function related to feeding or nutrition. Indicators that place an individual at risk include, but are not limited to, a history of aspiration or aspiration related illness, unexplained weight loss or serious departure, from ideal body weight range, history of eating inedible objects, history of rumination, history or recent incidents of gastro-intestinal disorders or difficulty, uncontrolled eating or unsafe eating behaviors, oral-motor dysfunction,

residents fed by alternative methods, such as tube feedings, and persons at risk for any of the above conditions.

4. Formulate a treatment strategy, in consultation with a resident's Inter-Disciplinary Team, for each resident with feeding, nutrition or related problems.

5. Develop, in accordance with the treatment strategy, and implement a nutritional management plan for each resident including: positioning the resident (before, during, and after mealtimes) specific instructions to the person feeding and/or supervising the resident, and information to food service staff regarding consistency of diet or other dietary related information.

6. Train the staff who will feed the resident to competency on each specific feeding technique, procedure, and/or instruction contained in the individual nutritional management plan, including positioning.

7. Monitor the staff during mealtimes to ensure that the nutritional management plan is implemented as designed.

8. At least quarterly, a member of the Clinical Team will review each resident's nutritional management plan and the implementation of the plan, assess the effectiveness of the plan, report on progress to the Inter-Disciplinary Team, and make revisions to the plan, as needed, to improve effectiveness and

ensure that the resident is fed safely and properly.

9. Document for each resident the activities of the Clinical Team and its effectiveness, including a record of problems found in the implementation of the nutritional management plans.

10. At such time as the Clinical Team has completed competency-based training of staff for each resident's Nutritional Management Plan and is confident that staff are prepared to assume responsibility for feeding each resident, the team may assume an oversight role with specific staff assigned responsibility for day to day implementation of the nutritional management plan.

11. Individuals whose risk status has stabilized through medical, therapeutic, or behavioral interventions can be placed in a follow along status and removed from the regular case load of the Clinical Nutritional Management Team. For residents in follow along status, the Clinical Nutritional Management Team will review their cases monthly for six months and annually thereafter with the assigned feeding specialist to determine maintenance of safe and effective feeding.

M. Clinical Team members will conduct training on general nutritional management principles for all staff having direct contact with residents. Professional staff as well as direct care staff will be involved in this training and in mealtime activities.

N. ADC departments and ADC administration will assist and support the Clinical Teams to ensure the involvement of appropriate staff, particularly professional staff, in mealtime activities in accordance with general nutritional management principles and resident-specific nutritional plans.

VIII. NURSING

Defendants must ensure that nurses at ADC are providing adequate nursing care. To this end, and at a minimum, Defendants shall ensure that nurses are trained to and do perform the following functions:

A. Properly identify or evaluate residents experiencing acute events such as vomiting, increased respiratory rate or other acute episodes, to determine the etiology of the event or illness.

B. Recognize and react to significant changes in residents' nutritional and medical status, such as weight and hydration.

C. Routinely perform ongoing monitoring of serious medical conditions, including such basic procedures as taking vital signs.

D. Respond to crucial information provided by other sources to allow appropriate interventions to medical problems to occur;

E. Timely examine the results of medical tests such as laboratory tests, x-rays and other information essential

to provide adequate nursing and medical care.

F. Become familiar with the residents for whose care they are responsible and with their medications.

G. Administer medications in a manner consistent with basic nursing practices, in order to limit medication errors.

H. Properly record medication administration.

I. Monitor drug side-effects.

J. Ensure that residents do not experience unnecessary skin breakdowns.

K. Ensure the development of appropriate nursing care plans for residents.

IX. PROVISION OF CARE TO RESIDENTS WITH HEARING, VISION OR COMMUNICATION NEEDS

Defendants shall provide adequate and appropriate hearing, vision, and communication services to residents. To this end, and at a minimum, Defendants shall:

A. Assess, evaluate, develop, and implement programs, including the use of augmentive devices as needed, for each resident with communication deficits, including deaf or hearing impaired residents, to teach appropriate communication skills, including sign language and the use of communications boards. For hearing impaired residents for

whom amplification is effective, amplification devices shall be provided, along with any training necessary to allow the resident to use or become accustomed to wearing such devices. On units housing resident who are being taught sign language, at least one direct care staff person on each shift shall be taught sign language.

B. Assess and evaluate each resident with a vision impairment to determine his or her need for eyeglasses. Where needed, eyeglasses shall be provided along with training designed to ensure the resident can and does wear them. Defendants must provide training and services for individuals who are blind and provide assistive devices, such as canes or other trailing devices.

X. PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

Defendants shall provide adequate and appropriate physical and occupational therapy services to all ADC residents who need such services, including proper positioning, adequate equipment, including wheelchairs, and adequate physical therapy interventions. The goal of residents' physical therapy programs at ADC shall be to enhance the capacity of the individual to function, i.e., to help him or her to live safely and as independently as possible. To this end, and at a minimum, Defendants shall:

A. Adequately assess all ADC residents to determine their need for physical therapy (PT) services.

B. Ensure that PT evaluations, physical management plans, interventions, staffing, staff training, the

"school based" physical therapy program and quality assurance of all the above are adequate to address the physical therapy needs of residents.

C. Provide adequate physical therapy services to enable residents to develop functional skills, and to avoid and ameliorate deformities, contractures, and inappropriate body growth. Defendants shall have physical and/or occupational therapists with expertise in the field of developmental disabilities will evaluate all residents who have a physical disability, who require any special handling techniques (e.g., due to behavior problems, health problems, sensory deficits, etc.), or who have a nutritional management plan. The evaluation and treatment recommendations will include, at a minimum: (a) observation and analysis of movement during functional activities in natural environments; (b) obtaining information about and evaluating physical therapy-related concerns of direct care staff and other interdisciplinary team members; (c) evaluating appropriateness of current wheelchair and other assistive technology, and possible need for assistive technology; and, (d) determining status of and/or potential for contractures, deformities, and pressure ulcers. Treatment recommendations will include, at a minimum, information regarding the need for the following: (a) direct physical and/or occupational therapy services, including the frequency of those services, by whom these services will be provided (registered therapist, therapy assistant, therapy aide); (b) a 24 hour a day physical management plan and the major elements of the plan, if it is needed; (c) formal and/or informal training goals or instructions for staff interaction; and (d) adaptive devices and/or therapeutic equipment.

D. Provide and utilize appropriate and necessary

adaptive equipment for ADC residents who need such equipment.

E. Properly assess and treat acute orthopedic disorders and provide needed orthopedic devices; obtain consultations as needed.

F. Ensure that all residents in wheelchairs have chairs appropriately designed for their individual needs. No sling back or sling seat chairs shall be used, except for temporary transportation.

G. Ensure that PT, education and direct care staff are trained to enable them to properly position residents in their wheelchairs or other adaptive equipment. Defendants shall initiate regular, professionally designed and taught inservice training for direct care workers and other staff in positioning, transferring, and implementing physical therapy programs for physically handicapped residents.

H. Ensure that staff actually monitor and correctly position residents throughout the day and implement a quality assurance program to monitor that residents are correctly positioned throughout the day. For individuals who require such positioning, Defendants shall develop a written physical management plan that details, at a minimum, the following:

a. A schedule for therapeutic positions for the resident 24 hours a day, seven days a week, that have been identified as facilitating functional movement, preventing or reducing contractures or deformities, and/or improving general health. The physical management plan will be integrated with other

activities in which the resident is engaged.

b. Handling, lifting, and transferring techniques, including specification of the number of persons required to lift the resident. c. Therapeutic equipment and/or adaptive devices required by the individual to facilitate functional movement, prevent or reduce contractures or deformities, and/or improve general health.

d. Any special precautions required to safely and properly handle, position, and/or transfer the resident.

e. The name and position of the staff person responsible for: training other staff in the physical management plan, the resident's functional goals and outcomes, the therapeutic positions, the handling and transfer techniques: obtaining recommended devices and equipment; and for oversight of the implementation and the evaluation of the effectiveness of the plan.

I. Acquire sufficient physical therapy staff, including physical therapists and assistants, and occupational therapy staff to provide adequate physical therapy and occupational therapy services to residents in need of such services.

J. Hire a Director of Therapy and Special Services with the following qualifications:

a. A degree in physical therapy or occupational therapy with recent experience providing occupational

or physical therapy services to persons developmental disabilities, including those with severe neuromotor and musculoskeletal impairments. Experience with school-age children and adults is preferable.

b. Knowledge of current literature and contemporary practices related to occupational and physical therapy services for persons with severe developmental disabilities, including: (1) appropriate assessment and intervention, including assistive technology and (2) service delivery models that promote acquisition, retention, generalization, and maintenance of meaningful functional skills.

The Director of Therapy and Special Services will be responsible for, among other duties, supervising all professional staff providing therapy services for training or obtaining training for such staff, for maintaining an adequate continuing-education program, for providing consultation on individual cases, for ensuring physical and occupational therapy staff appropriately participate in interdisciplinary teams, for staff recruitment and retention and overseeing a quality assurance program relating to the efficacy and sufficiency of therapy services provided at ADC.

J. Retain a qualified consultant to assist them in implementing the above requirements.

XI. INDIVIDUAL WITH DISABILITIES EDUCATION ACT

Defendants shall, within the time frames set forth, take the following measures to fully comply with the Individuals

with Disabilities Education Act (IDEA) 20 §§ U.S.C. 1400 et seq., and applicable state law. The requirements of this section of the Order shall apply to all school-age children currently residing at ADC. To this end, and at a minimum, Defendants shall:

A. Retain the services of a consultant(s) with proven expertise in the field of special education services to perform or coordinate performance of the following services for school-age children at ADC in conjunction with educators affiliated with the Shelby County Public School system:

1. Thoroughly assess and evaluate the educational needs, strengths and deficits of school-age children.

2. Use the assessments and evaluations developed pursuant to Paragraph 1 above to develop a comprehensive statement of each student's present level of performance as the basis for development of each child's Individualized Education Plan (IEP).

3. Provide in each student's IEP comprehensive short-term and long-term training objectives sufficient to address his or her unique educational needs.

4. Provide objectives are functional to each student in each IEP.

5. Identify specific education services to be provided each child in each IEP in order to achieve his or her learning objectives.

6. Write training objectives in such a manner that

performance can be objectively measured and that education goals cover no more than a 12-month period, beginning with the staffing date.

7. Develop and implement a system to provide for the generalization and maintenance of skills learned in the classroom.

8. Develop and implement adequate recordkeeping procedures to ensure that students' progress in meeting educational objectives is accurately monitored;

9. Adequately train educational staff to implement the IEPs; and

10. Provide related services, including, but not limited to, psychological services, physical and occupational therapy, and speech and language services, as necessary to allow children the benefit of special education services; and

11. Fully implement all IEPs.

B. Defendants shall place all school-aged children at ADC in appropriate educational programs consistent with recommendations contained in their IEPs in the Shelby County public school system by September 1996.

XII. RECORDKEEPING

Defendants shall maintain records and record keeping systems

adequate and appropriate to effectuate the terms of this Order.

XIII. RESIDENT PROPERTY

ADC will ensure residents' rights to own, keep and reasonably use personal possessions and property.

XIV. ADMISSION AND PLACEMENTS

A. Defendants shall reduce the population of ADC to 200 persons or fewer by September 30, 1997.

B. Defendants will ensure that residents are placed in an appropriate and safe manner and that placements in the community are adequate to meet the needs of the individuals there placed. In order to effectuate this requirement, the Defendants will, at a minimum, comply with the following:

1. Defendants are enjoined from admitting any additional residents to ADC except for emergency, short-term court-ordered admissions.

2. All ADC residents who were age 21 or under as of January 21, 1992, shall be placed in an appropriate community residence by no later than September 30, 1997. Defendants will exert their best efforts and give priority to community placement of 75% of these individuals by September 30, 1996.

3. The nature of an individual's disability will not be a factor in the eligibility of that individual for placement consideration.

4. Defendants shall evaluate and develop an individualized placement plan (IPP) for each ADC resident who will be placed to ensure placement in appropriate, professionally developed, community-based programs which fully meet his or her individualized needs.

5. No ADC resident will be placed in a nursing home or other non-community placement, such as other state or private institutions.

6. Each IPP shall specify in detail the number and kind of programs and facilities needed, including residential, day programs, and specialized medical services, to serve the individual resident in the community. All services shall be integrated into the community to the maximum extent possible. Transition services, including home visits and overnights, as well as any other steps that need to be taken to ensure an orderly and smooth transition for the resident, must also be included in the IPP. Training for community facility staff must include meetings at ADC with staff familiar with the resident to be transferred prior to the actual placement.

For school-age children, the IPP shall also include a statement of the educational program, including related services and transportation services, to be provided each child. No child shall be placed in any setting that is not fully capable of providing the educational services required by the Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400-1485. All placements of children in residential settings must

also comply with all applicable Tennessee state laws with regard to special educational services to handicapped children.

7. Defendants shall ensure that the community placement for each and every ADC resident meets the individual needs of the resident, as identified in the IPP. Under no circumstances will the speed or type of a placement be governed by anything other than the interests of the resident being placed. In order to accomplish this, the Defendants may use existing community placements only where they have certified that the placement meets the needs of the resident as identified in the IPP. Where there are no existing placements to meet the resident's needs, Defendants shall create or contract for a community placement that meets the needs of the resident as identified in the IPP. Defendants shall similarly certify that the new placement shall meet the needs of the resident as identified in the IPP.

8. The IPP and the placement certification for each resident will be filed with the Monitor 60 days before each placement is to occur. The Monitor shall review each IPP and placement certification to determine the adequacy of the placement. In situations where the Monitor determines the placement is not adequate, no placement shall occur until the issue is resolved.

9. Defendants shall afford residents, parents and guardians an opportunity to participate in the placement process.

10. Defendants shall ensure that each resident placed in a community-based program pursuant to this order has an advocate selected by a process developed by Defendants.

11. Community placements shall be required to provide a safe and humane environment in which individuals are provided daily opportunities to learn, develop and maintain skills. All services, including medical and other health related services (e.g., physical therapy, occupational therapy, dental, speech and hearing, nutrition), and psychology, must be adequate and appropriate to meet the individual needs of the residents.

12. Defendants shall develop a case management system sufficient to ensure that the needs of each resident placed in a community-based program pursuant to this Order are consistently reviewed and met. Every resident will have a case manager. No case manager shall have a case load in excess of 30 developmentally disabled persons. Case managers will be supervised by and report to a designated staff person of DMHMR and will receive a minimum of eighty hours training in the requirements identified in Paragraph P in addition to other job-related training.

Case managers will be in regular, frequent contact with the people on their caseload in both their residential and day program or work site. Case managers will observe participation in programs and therapeutic interventions and will evaluate the degree to which services in the individualized plan are being

delivered. In no event will case managers visit each of their assigned residents less than once every two weeks.

13. Defendants shall survey all community-based programs and facilities operated or supported by state funds in which former ADC residents placed pursuant this Order reside at least annually to determine compliance with requirements referenced in Paragraph P herein. Reviews of the medical, psychological and psychiatric services available to these former ADC residents also must occur on an annual basis by experts chosen by the Monitor in each area being reviewed. Defendants shall ensure that all deficiencies found in community placements are remedied promptly. Defendants shall address continuing deficiencies in community placements by sanctions against the providers.

14. Investigations of all abuse or neglect allegations in community placements or programs in which residents covered by this Order reside must be done by trained investigators who report directly to the Assistant Commissioner of DMHMR.

15. Reports for each residence or program surveyed by Defendants pursuant to this Order shall be forwarded to the Monitor within 30 days of the site visit component of the survey.

16. All community-based programs and facilities covered by this Order shall meet state and local licensure requirements, DMHMR regulations and

applicable fire safety codes. Defendants must also ensure that all such community-based programs meet the requirements of Defendants' waiver plan and Defendants' current Quality Assurance Guidelines for Community Mental Retardation Services.

17. All residents being placed from ADO automatically shall be deemed eligible for a waiver for a period of time not less than five years.

18. Defendants shall provide sufficient funding to fulfill the requirements in this agreement.

19. The Monitor is permitted unrestricted access to the community placements of former ADC residents placed pursuant to this Order and documentation regarding such placements for so long as the Court retains jurisdiction in U.S .v. Tennessee. The United States may have access to documentation regarding such placements upon request and access to the community placements of former ADC residents when issues regarding compliance with this Order are raised by the Monitor.

Deficiencies identified by either the monitor or the United States in community placements must be addressed by Defendants immediately in accordance with Paragraph M.

XV. APPOINTMENT, DUTIES AND PRIVILEGES OF MONITOR

A. Following approval of this Order by the Court,

the Court will appoint a Monitor to evaluate the Defendants' compliance with the provisions of this Order.

B. The duties of the Monitor will include:

1. Conduct on-site reviews at ADC and community placements of former ADC residents covered by this Order at least semiannually to determine compliance with all provisions of this Order. A reasonable number of expert consultants may be retained to assist the Monitor in these reviews.

2. Produce a Compliance Report after each review which contains the results of the on-site review and a summary of the information contained in reports submitted by ADC, including any follow-up action taken by the Monitor. This report should be submitted to the Court and both parties.

3. Be available by phone, correspondence and, when needed, in person to the residents and staff of ADC, parents and guardians of residents of ADC, parties to this litigation, and to the Court.

4. Review all ADC policies and procedures adopted to implement the objectives of this Order and provide advice to Defendants regarding the efficacy and appropriateness of such policies and procedures.

5. Undertake special assignments, tasks, and investigations as may be requested or ordered by the Court.

6. Prepare and submit to the Court, with a copy to Defendants, annual budgets for all costs associated with the duties and responsibilities of the Monitor and revise these as necessary to accomplish special assignments, tasks, and investigations if these are required by the Court. The Defendants will have fifteen (15) days after receipt to submit any comments to the Court.

7. Submit monthly invoices to the Court for reimbursement, with a copy to Defendants. The Defendants will have fifteen (15) days after receipt to submit any comments to the Court.

C. The Monitor will have unlimited access to all residents, staff, consultants, records (including individual resident's records), files (other than files of the ADC attorney), facilities, buildings and premises subject to this action. The Defendants will not refuse any reasonable request by the Monitor for documents or other information and will permit confidential interviews of staff. At the Monitor's request, a single representative of the Defendants will coordinate tours of ADC and community placements and gather documents or other information requested by the Monitor. The Monitor need not give advance notice of any tours of ADC but will give reasonable notice of intent to review documents that must be gathered in order to facilitate a review. These provisions will also apply to any consultant retained by the Monitor.

D. Retaliation against any state employee, ADC resident, or family member provided information to the Monitor or the Court or the United States is strictly prohibited

and will be a violation of this Order, subjecting Defendants to contempt sanctions by the Court. A notice to this effect must be posted in all locations where employee and public notices are posted.

E. The Monitor will be copied on all motions to the Court and correspondence between the parties.

F. The Monitor's notes and files will not be subject to discovery by either party.

G. In instances described in this Order in which the Monitor may give or withhold approval, the Monitor's decision must consider the reasonableness, feasibility and efficacy of the proposed modification in satisfying the terms of this remedial Order. In all instances in this Remedial Plan in which approval by the Monitor is specified, the Monitor's decision is effective immediately and will remain in effect unless overturned by the Court. If either party disagrees with the position taken by the Monitor, the following recourse will be available:

a. The dissatisfied party will inform the Monitor in writing of the basis for its disagreement with the Monitor's decision within ten working days; the other party will be given an opportunity to comment within ten working days; the Monitor will reconsider the decision to approve or disapprove and make a final decision within five working days of the receipt of the last set of party's comments.

b. If the dissatisfied party disagrees with the

Monitor's reconsideration of the approval decision, the party may present the issue to the Court for determination within five working days of the Monitor's final decision.

XVI. ACCESS BY UNITED STATES

The United States and its attorneys, consultants and agents shall have reasonable access to the facilities, records, residents and employees of ADC. The United States is not required to give Defendants advance notice of its intent to tour ADC. Such access to ADC shall include, but not necessarily be limited to, the following:

A. Nothing in the Order shall preclude the United States from conducting additional discovery pursuant to the Federal Rules of Civil Procedure, such as, but not limited to, depositions or requests for admissions, on matters relating to enforcement or compliance with the Order.

B. Defendants shall bear all Costs related to copying or otherwise supplying the United States or the Monitor with documents requested by the United States or the Monitor that relate to the Defendants' compliance with the Order.

C. The United States shall have access to all ADC records and documents, subject to the provisions of VI (L). Defendants shall provide to the United States copies of all documents provided to the Monitor upon request of the United States, subject to the provisions of VI (L).

D. The United States shall have reasonable access to speak with all ADC employees or consultants. Counsel for Defendants may be present during such interviews, if counsel so desires, provided such presence does not restrict or limit the United States' access to the ADC employees or consultants.

F. If employees or consultants of Defendants, on their own initiative, express a desire to speak privately with representatives of the United States, they shall be permitted to do so without repercussions by Defendants. Furthermore, retaliation against any individual, family member or resident based on communication with the United States is strictly prohibited. A notice to this effect must be posted in all locations where employee and public notices are posted.

G. Defendants reserve the right to seek relief from the Court in the event that the United States' access proves to be unreasonable.

XVII. TIME FRAME FOR IMPLEMENTATION

The Order requirements herein will be achieved by Defendants in accordance with the Schedule of Implementation, attached as Attachment A to this Order.

XVIII. RETENTION REVIEWS

A. In order to effectuate the delivery of care consistent with constitutional requirements, the Superintendent will conduct retention reviews of all ADC employees. In making retention reviews, longevity within the institution or the State of Tennessee will not be a basis for

retention.

1. During a period of one year beginning September 1, 1994, the Superintendent of ADC will review for retention each professional staff person at ADC. Professional staff persons include those persons serving in positions such as administrators; physicians; dentists; dental hygienists; pharmacists; nurses; physical, occupational, speech, communication and recreation therapists; dieticians; psychologists; audiologists; social workers; educational and vocational instructors; or in positions with equivalent titles.

2. During a period of eighteen (18) months beginning September 1, 1994, the Superintendent of ADC will review for retention all other staff at ADC.

3. Staff who are retained by the ADC Superintendent during the period of review, but whose permanent retention was deemed questionable, will be given one year of conditional retention while final determination is being made.

XVIV. JURISDICTION AND ENFORCEMENT

A. The Court shall retain jurisdiction of this action for all purposes under this Order until this action is dismissed.

B. (1) After this Order has been in effect for at least three years, the Defendants may petition this Court for' termination of this Order, in whole or in part, on grounds that they have achieved and demonstrated

their ability to maintain compliance with its provisions.

(2) Upon filing of such a petition, the United States shall have 60 days within which to tour and respond. Thereafter, the Monitor will conduct a review of the compliance issues raised by the petition and response and report to the Court and the parties on the results of that review. The Court will conduct a hearing as soon as practicable thereafter.

C. The falsification of records, data, correspondence or other information required for determining the Defendants' compliance with this Order is strictly prohibited and will be a violation of this order, subjecting Defendants to contempt sanctions by the Court. A notice to this effect will be in all locations where employee and public notices are posted.

DONE and ORDERED this 2 day of September, 1994 at Memphis, Tennessee.

/s/_____
Jon Phipps McCalla
United States District Judge

FOR THE STATE OF TENNESSEE:

/s/_____
CHARLES W. BURSON
Attorney General & Reporter

FOR THE UNITED STATES:

/s/_____
DEVAL L. PATRICK
Assistant Attorney General

/s/_____
LINDA A. ROSS
Associate Solicitor
General
JANICE L. TURNER
Assistant Attorney
General

/s/_____
ARTHUR E. PEABODY, JR.
Chief Special Litigation
Section Civil Rights Division

/s/_____
LAURIE J. WEINSTEIN
ROBERT C. BOWMAN
VERLIN P. HUGHES
WILLIAM G. MADDOX

APPENDIX O

RULES OF CIVIL PROCEDURE

Rule 23. Class Actions

(a) Prerequisites to a Class Action. One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:

(1) the prosecution of separate actions by or against individual members of the class would create a risk of

(A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or

(B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

(c) Determination by Order Whether Class Action to be Maintained; Notice; Judgment; Actions Conducted Partially as Class Actions.

(1) As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be so maintained. An order under this subdivision may be conditional, and may be altered or amended before the decision on the merits.

(2) In any class action maintained under subdivision (b)(3), the court shall direct to the members of the class the best notice practicable under the circumstances, including

individual notice to all members who can be identified through reasonable effort. The notice shall advise each member that (A) the court will exclude the member from the class if the member so requests by a specified date; (B) the judgment, whether favorable or not, will include all members who do not request exclusion; and (C) any member who does not request exclusion may, if the member desires, enter an appearance through counsel.

(3) The judgment in an action maintained as a class action under subdivision (b)(1) or (b)(2), whether or not favorable to the class, shall include and describe those whom the court finds to be members of the class. The judgment in an action maintained as a class action under subdivision (b)(3), whether or not favorable to the class, shall include and specify or describe those to whom the notice provided in subdivision (c)(2) was directed, and who have not requested exclusion, and whom the court finds to be members of the class.

(4) When appropriate (A) an action may be brought or maintained as a class action with respect to particular issues, or (B) a class may be divided into subclasses and each subclass treated as a class, and the provisions of this rule shall then be construed and applied accordingly.

PARTIES

(d) Orders in Conduct of Actions. In the conduct of actions to which this rule applies, the court may make appropriate orders: (1) determining the course of proceedings or prescribing measures to prevent undue repetition or complication in the presentation of evidence or argument; (2)

requiring, for the protection of the members of the class or otherwise for the fair conduct of the action, that notice be given in such manner as the court may direct to some or all of the members of any step in the action, or of the proposed extent of the judgment, or of the opportunity of members to signify whether they consider the representation fair and adequate, to intervene and present claims or defenses, or otherwise to come into the action; (3) imposing conditions on the representative parties or on intervenors; (4) requiring that the pleadings be amended to eliminate therefrom allegations as to representation of absent persons, and that the action proceed accordingly; (5) dealing with similar procedural matters. The orders may be combined with an order under Rule 16, and may be altered or amended as may be desirable from time to time.

(e) **Dismissal or Compromise**. A class action shall not be dismissed or compromised without the approval of the court, and notice of the proposed dismissal or compromise shall be given to all members of the class in such manner as the court direct. (As amended Feb. 28, 1966, eff. July 1, 1966; Mar. 2, 1987, eff. Aug. 1, 1987).

APPENDIX P

EXCERPTS FROM DEPOSITION OF WILLIAM J. KNAUS

[p.146]

Q. Now, sir, I'd like to go to the question which in my letter to you is No. 3 on consensus of professionals in the field.

MR. LASKI: Note my standing objection to this line of questioning.

Q. (By Mr. Sherman) Did you in your preparation for this deposition address the question whether there is any consensus in the professional field, professionals concerned with mental disabilities, whether all persons with disabilities should live in community settings?

A. First of all, yes, I did.

Q. Can you summarize, sir, beyond, what you've already done, what you did in preparation for this deposition on that issue?

A. I looked at the issue of the consensus in the sense of the area where you're trying to make a determination of what is in the best interest of the individual in terms of a wide range of factors which are not always going to be consistent because of the variability between people and the individual differences.

And consensus under those conditions is wrong,. whether -- it doesn't matter whether the consensus is

[p.147]

towards remaining in the institution. The consensus is towards should all people be in the institution, for instance. That consensus would be incorrect. All people should be out of the institution --

(An Interruption in the Proceedings.

MR. SHERMAN: Back on.

MR. LASKI: The question was consensus of all persons living in community settings.

Q. (By Mr. Sherman) Did you review the literature seeking to answer whether or not there is any consensus among mental health or mental retardation professionals?

A. I looked for surveys and I found a dissertation which related to some two hundred -- I forget exactly the number of people, I could probably pull it out, but there tended -- there was more people inclined toward deinstitutionalization than not but other than that I didn't find any data and the quality of the dissertation is questionable.

What I did find though is and this is not recent, this goes back to the '70s, is that there is a cross

current of views that serves as a chart between views. One view tends to be ideologically driven which is the focus there is on the closing of the institutions and the other view is, you know -- I don't see anybody, by the way, that

[p.148]

I've been able to determine that said that people need to remain in institutions and should not be provided with opportunities to live reasonably normal lives, existences in the community.

That there seems to be a consensus in terms of the value of the normalization approach. And the difference though is in terms of implementation of that approach. That the ideological group tend to take the position that you suggested which is let's close down the institutions and move people into the community and the implication is the community is curative.

Q. Do you have the article you mentioned?

A. Yes, I do.

Q. Will you identify the article, please?

A. Actually quite a few articles but the more temperate views, focus on individual differences and it's probably in my red folder. Yes.

Q. Th· article you mentioned?

A. Normalization and the Deinstitutionalization of Mentally Retarded Individuals, subtitle Controversy and Facts. Author Sharon Landesman, L-A-N-D-E-S-M-A-N and Earl C. Butterfield. The article appeared in the American Psychologist, August 1987.

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Q. And do you have an extra copy of that?

A. Yes. I gave it to you.

MR. SHERMAN: Off the record again.

(Discussion off the record.)

MR. SHERMAN: On the record.

Q. (By Mr. Sherman) So you do have a copy of this article? Is the American Psychologist a well-known publication?

A. The American Psychologist goes out to all members of the American Psychological Association. It's a well regarded journal which is a peer review journal. It's the premiere of journals of the American Psychological Association.

Q. You said 1970. Was that a mistake?

A. August 1987.

Q. '87. Now, does this article encapsule many of the

issues and discussions over deinstitutionalization?

A. It presents a very adequate and full review of what the issues are.

Q. And a summary of social reform?

A. Yes.

Q. In recent years, that is the last thirty years?

A. I don't know if it goes back thirty years.

[p.150]

Q. I see. On the first page, Social Reform in the Treatment of Mental Retardation 1967 to 1995. That's twenty years there and there is a discussion on normalization and deinstitutionalization?

A. It identifies deinstitutionalization and normalization at least restrictive environment is the focal point.

Q. And the data base and the role of social science?

A. Yes. In general it sets forth the position which is -- you have two main trends which is the ideological trend and then you have a trend towards based on individual differences and needs.

And so one size fits all is one position and the other position is one size may not fit all. The one size fits all position might also relate to the notion that

people are going to be better off in a community, that people are better off in the community and institutions are dehumanizing and that because of that the focus should be on the development of community residency for people who are currently in institutions.

Q. I want to ask you to read the second paragraph on the first page if that expresses what you are saying?

A. "Deinstitutionalization and normalization are

[p.151]

probably the most controversial and emotionally charged issues in the field of mental retardation. Their merits and liabilities are debated passionately in courtrooms, legislative hearings, parent meetings, social and health service agencies, professional societies and the media."

"Testimony invariably includes accounts of the phenomenal progress of previously institutionalized individuals after they were moved to small community homes and vivid descriptions of shameful conditions that still exist in state institutions, countered by horror stories of deinstitutionalized persons who are isolated, neglected or abused in the community and by glowing reports of model programs conducted within institutions."

Q. And the third paragraph developing that point further?

A. Yes. Fundamental beliefs and values.

Q. Can you take that and summarize Paragraph 3 by reducing it, but within quotes, where it discusses "at the heart of the debate are fundamental differences in beliefs and values" unquote?

A. "At the heart of the debate are fundamental differences in beliefs and values about the extent to which the environment affects the functioning of those who are

[p.152]

retarded and what types of environments are best for whom."

"Proponents of deinstitutionalization and normalization recognize that community placement involves risk and raises complex questions about how to promote true social integration, but they do not doubt that the risk is justified and that living in the community promotes a better quality of life and safeguards human rights."

"Opponents stress the need of many who are mentally retarded to have protective, caring and cheerful environments and to receive technically sophisticated training and health support systems prior to community placement."

"Although it is not apparent in the heat of debate, almost all would agree minimally restrictive community living is a highly desirable goal for most

citizens with mental retardation. As goals, normalization and deinstitutionalization are not terribly controversial as means to achieving these goals, many of the current practices related to deinstitutionalization and normalization are."

Q. Can you point further in the article to the points about the role of ideology if you can? Perhaps

[p.153]

under normalization. Was that the principle which was first introduced by Dr. Wolfensberger?

A. According to this article it is. "The concept of normalization first emerged from efforts to improve services in Scandinavia. In the United States Wolfensberger expanded this principle into a comprehensive ideology with detailed guidelines for providing and evaluating human services."

"Simply stated normalization is the utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible."

"Within this framework, life satisfaction, self-esteem and personal competence are viewed as products of involvement with mainstream activities of society."

"Also, participation in atypical, segregated or

specialized environments and affiliation with other socially devalued persons are considered detrimental to an individual's development."

Q. There follows, does there not, a summary of the statutory and case log development in this country, the DDA Bill of Rights Act of 1975 and the Pennhurst case in 1977

[p.154]

but goes to Page No. 3 of the article. I don't mean to lead but it's --

MR. LASKI: You can go through it.

MR. SHERMAN: It also discusses the Chafee Bill, does it not, the bill which would have resulted in the closure of all facilities in the country above --

MR. LASKI: I'll object to that.

MR. SHERMAN: I think it says phased out. This is Page 3. Phasing out all facilities with more than fifteen residents?

THE WITNESS: Okay.

Q. (By Mr. Sherman) Now -- and then the point of ideology, Dr. Knaus, where does that pick up again in this article?

A. The point of ideology is actually back on the

preceding page.

Q. We passed it?

A. We passed it.

Q. Did this article create a debate at the time?

A. Yes, it did.

Q. Between proponents and opponents of deinstitutionalization at least as it was being pursued at that time?

[p.155]

A. Yes.

Q. And are you able to tell this court the nature of that debate, if you know? Did it generate articles, for example?

A. Yes. Well it generated at the least comments about the article. One of the statements is in contrast to statements regarding the mainstreaming of society. One which states that, "The pattern of deinstitutionalization has differed for mentally retarded versus mentally ill individuals. In the field of mental retardation deinstitutionalization began twelve years later than in the mental health field, occurred more gradually and selectively, involved less recidivism" --

Q. What are you referring to?

A. 810.

Q. Of the same article?

A. Same article and providing some sense of background. "And was accompanied by fairly stable rates of new admissions. But for both mentally ill and mentally retarded clients, the zeal and dedication that have motivated deinstitutionalization have left in their wake a series of dysfunctional elements resulting directly from rapid, sometimes heedless, implementation of incomplete

[p.156]

program plans."

"Planning for deinstitutionalization has unfortunately often proceeded in a sort of functional vacuum. It has certainly failed to address the needs of the diverse patient population subgroups comprising the union of mentally disabled persons."

MR. LASKI: Objection. Comprising the universe of?

THE WITNESS: Comprising the universe of mentally disabled persons. Excuse me. According to the --

MR. LASKI: I'm going to object. It's simply a reading of the column and we can read it.

APPENDIX Q

Colloquy

[p.32]

THE COURT: I don't think it is nearly that broad. I don't see it as that broad at all. Let's say that there is a high functioning individual at the institution who is interested in meeting with individuals regarding religious concerns. Let's say that that individual doesn't even have a parent or a guardian, there are some people in that circumstance, and yet staff in the past has precluded that individual from meeting with the local Methodist minister. The person said I want to meet with Reverend Smith. Reverend Smith comes and says I want to — I want to meet with the patient. This says — all this says is that — and there is some reasonable restriction, I mean I don't anticipate a policy where there is no input by the — if there is a guardian or if there is a parent, it may be one set of considerations in the policy. If there is not a guardian or a parent and it is a high functioning individual, they certainly are going to have a different set of circumstances. So it is not revolutionary that these individuals will be allowed to associate with or communicate with individuals of their choice. Now, we all know that at Arlington there are a number of categories of residents, some much more able to exercise First Amendment rights than others, and some having probably very little ability to exercise First Amendment right. I'm really looking to Mr. Campbell for some verification, is that right?

[p.33]

THE WITNESS: That's correct, yes, sir.

THE COURT: And some having very little ability to do that, some having a good bit of ability to do that?

THE WITNESS: That's correct.

THE COURT: And it may well be that a fairly small number of people will be in a position to really exercise those rights, but this will simply put in place a procedure to make sure that they can do that.

THE WITNESS: That's correct.

THE COURT: Now, I don't perceive this as meaning that being able to exercise those rights, that if a person is going to be placed in the community, you're not still going to talk to the parent or guardian if that individual has a parent or a guardian, that you have an obligation to visit with and talk with the parent guardian, take into consideration what they're concerned about, certainly take into consideration the adequacy of the facility to which that individual would be placed, hear from them and really try to have as much as you can a joint decision regarding those important things, one in which the resident, if the resident is a higher functioning individual and can be talked with and have some discussions or have as much communication as possible, the parent and guardian have as much communication as possible, and you can — and that's really not exactly — but it all — it is all the same kind of encouragement of participation by the resident in

APPENDIX R

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

NO. C96-5906FDB

FILED
May 1, 1997
CLERK US DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT TACOMA
BY DEPUTY

PEOPLE FIRST OF WASHINGTON, INC. *et al.*,
Plaintiffs,

vs.

RAINIER RESIDENTIAL HABILITATION CENTER, *et al.*,
Defendants.

ORDER DENYING MOTION FOR CLASS CERTIFICATION

This matter comes before the court upon Plaintiff's Motion for Class Certification. Since the motion was filed, an amended complaint has been filed, and the Motion of Friends of Rainier, Inc. ("FOR") to intervene has been

granted. Under these conditions, and based upon the Defendants' arguments against class certification and the stated intentions of FOR to oppose class certification, the present motion for class certification will be denied.

At this point, the prerequisites to a class action, enumerated in Fed. R. Civ. P. 23 (a) do not appear to be satisfied, particularly as to whether the claims of the representative parties are typical of the putative class and whether the representative parties will fairly and adequately protect the interests of the class. Neither do the elements outlined in Fed. R. Civ. P. 23(b) appear to be satisfied, particularly as to whether the defendants have acted or refused to act on grounds generally applicable to the class. Moreover, it is not clear that with respect to the nature of the relief sought, a class action is necessary, since a grant of injunctive or declaratory relief based on constitutional and/or statutory violations would necessarily apply to affected persons whether or not a class were certified.

Accordingly, it is hereby

ORDERED: Plaintiffs' Motion to Certify Class is DENIED.

DATED this 1 day of May, 1997.

/s/_____
FRANKLIN D. BURGESS
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

NO. C96-5906FDB

FILED
May 1, 1997
CLERK US DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT TACOMA
BY DEPUTY

PEOPLE FIRST OF WASHINGTON, INC.) *et al.*,)
Plaintiffs,)
)
vs.)
)
RAINIER RESIDENTIAL)
HABILITATION CENTER, *et al.*,)
Defendants.)
_____/

ORDER GRANTING INTERVENTION AS A DEFENDANT

This matter comes before the court upon Motion To Intervene, as a defendant, by Friends of Rainier, Inc. ("FOR") a Washington nonprofit corporation (existing since the early sixties, and incorporated in 1978) comprised of legal guardians, family members and concerned friends of residents at Rainier as well as family members of those who used to live at Rainier but who now live in the community.

FOR explains that there is "a great debate" in this country about how to best treat, care for, and accommodate the mentally retarded and developmentally disabled. On one side are those who say that large, institutionalized care is inhumane, unnecessarily restrictive, and vocative of human rights, and that all developmentally disabled persons should be placed in small, community-based programs. On the other side are those who say that a "continuum" of care is more appropriate; that is, that while some disabled persons can function in community settings, others are so severely disabled that, for them, an institution with centralized, constant protection and care is a better alternative. FOR acknowledges that on both sides are experts, examples of failure, and families with difficult choices and hard feelings.

Fed.R.Civ.P.24(a) provides for "Intervention of Right" where a party timely files an application for intervention, and

> when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

Rule 24(B) provides for "Permissive Intervention" upon timely application "when an applicant's claim or defense and the main action have a question of law or fact in common."

Plaintiff's object both to FOR's intervention of right

and permissive intervention for a number of reasons: (1) that FOR does not have significant interests that may be impaired by this lawsuit, (2) the interests of the parents in FOR will not be impaired, because while they might express their views, these views cannot override their children's constitutional rights, and the latter is what Plaintiffs seek to protect, (3) the interests of FOR are adequately represented by the State of Washington.

Considering the arguments of the parties, the Court concludes that the parents and legal guardians who are represented by FOR have the closest interest in the welfare of their charges who are Rainier residents and therefore should be included in the process of deciding the issues raised in this case. FOR's construction of the rights involved in this case may not necessarily totally track the either the interests of Plaintiffs or Defendants. The State concedes that it does not represent the parents and guardians but only the State Department of Developmental Disabilities. FOR represents the interests of its membership, as the individual family members and guardians vote in the organization.

Since at the time of filing this motion a motion for more definite statement was pending, and the Court meanwhile has granted the motion, resulting in a first amended complaint being filed on April 8, 1997, FR's not filing an answer with its motion to intervene is not fatal; FOR shall file its answer by Friday, May 9, 1997.

Accordingly, it is hereby

ORDERED:

Orders in Washington Case No. C96-5906FDB

(1) The Motion of Friends of Rainier, Inc. (FOR) to intervene as a defendant is GRANTED;

(2) FOR shall file its answer to the first amended complaint by Friday, May 9, 1997.

DATED this 1 day of May 1997.

/s/_____
FRANKLIN D. BURGESS
UNITED STATES DISTRICT JUDGE

APPENDIX S

U.S. DEPARTMENT OF JUSTICE
OFFICE OF LEGISLATIVE AFFAIRS

RECEIVED
March 15, 1991
SUPERINTENDENT'S OFFICE

ARLINGTON DEVELOPMENTAL
ARLINGTON, TENN.

Office of the Assistant Attorney General
Washington, D.C. 20530

REGISTERED MAIL
RETURN RECEIPT REQUESTED

Honorable Ned McWherter
Governor of Tennessee
Governor's Office
State Capitol
Nashville, Tennessee 37219

Re: Findings of Investigation, Arlington Developmental Center

Dear Governor McWherter:

By letter dated July 11, 1990, we notified you that, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq., the Civil Rights Division of the

DOJ Letter Of Finding

United States Department of Justice was commencing an investigation into conditions at Arlington Developmental Center (Arlington), a facility for mentally retarded persons located in Arlington, Tennessee. As specified by the statute, we are now writing to inform you of the conditions at Arlington that we have found are depriving residents there of their constitutional and Federal statutory rights, the facts supporting our conclusions, and the minimum measures we believe may remedy those conditions.

Our investigation consisted, first, of several comprehensive tours of Arlington with independent experts, most recently on December 14 and 15, 1990. We observed conditions in all the residential units of Arlington at various times of the day, interviewed administrators, staff and residents, and examined a variety of records. Further, we gathered and analyzed documentation relating to the operation of Arlington, including, but not limited to: a variety of policies and procedures; information relating to staffing; minutes from various committees; incident and injury reports; mortality reviews; abuse records. Throughout the investigation, we received complete cooperation from the administrators and staff at Arlington. We look forward to continued cooperation.

Based upon our extensive investigation, we have concluded that conditions at Arlington deprive its mentally retarded residents of their constitutional rights to adequate medical care, reasonable safety, and such training as an appropriate professional would consider reasonable to ensure their safety and freedom from undue bodily restraints, Youngberg v. Romeo, 457 U.S. 307, 324 (1982). These conditions, which seriously threaten residents' health and

safety, include:

1. Neglect and abuse of residents.

2. Failure to provide adequate medical care, specifically:

   (a) Failure to adequately diagnose and treat residents.

   (b) Failure to provide essential physical therapy services.

   (c) Failure to provide sufficient numbers of appropriately trained staff to render and implement professional judgments regarding necessary medical treatment.

3. Failure to provide required training to residents, specifically:

   (a) Failure to provide professionally designed individualized training and behavioral programs.

   (b) Failure to provide sufficient numbers of appropriately trained staff to implement professional judgments regarding training of residents.

4. Failure to provide a free appropriate public education for school-age residents as required by the Education of the Handicapped Act.

5. Failure to provide a safe environment.

1. Arlington Residents Are Subjected to Neglect and Abuse

The failure to provide care or training that a qualified professional would consider appropriate can be deemed "neglect". At Arlington, however, lack of care sometimes rises to active neglect, neglect that harms residents, many of whom spend their lives at the facility. One consultant who recently toured the facility voiced the concern that:

> Arlington has failed to implement even the most basic changes of the twentieth century. They are providing only the proverbial three hots and a cot. In doing so, they are creating a new generation of multihandicapped individuals, when in some cases, there is no need for these handicaps to exist, other than neglect.

During the investigation, we observed young children, some as young as two, whose limbs were severely contracted. Our experts believed that these contractures were avoidable. Many residents were left unattended in cribs, with no efforts being made to move their limbs, position them, or to provide any real physical therapy services. The failure to actively move, reposition, and exercise such residents results in potentially crippling and irreversible physical deterioration. We observed one five year old boy, unattended in his crib, hitting the side of his head with his fist due to a lack of stimulation. No one was paying attention to the boy other than an overworked direct care worker holding his arm when

and if she observed the behavior. The penis of another resident, a paraplegic with an in-dwelling Poley catheter, was eroded throughout its entire length due to inadequate care and monitoring. In many units, there was a pervasive smell of urine. Residents in diapers were wet; often their clothes were soaked through with urine. Besides the direct care staff shortages that permitted these conditions, there was an apparent tolerance of such conditions as well. Our agents concluded that this lack of care constitutes active neglect.

In three abuse investigations that we reviewed, outside physicians who were consulted by residents' families concluded that the residents had been abused. These were the only abuse investigations in which outside physicians had examined the injured Arlington residents. In these three cases. Arlington discounted the outside physicians' findings. As such, the investigations undertaken by Arlington and/or the department of Human Services (DHS) reveal a lack of commitment to uncovering such abuse or neglect, and, therefore, imply tolerance for such actions. A number of staff reported that it would serve no purpose to report abuse to the administration of Arlington; nothing would be done. This belief is confirmed by one case that we reviewed. In that case, direct care staff who belatedly reported that another direct care worker had abused a resident were disciplined more harshly for the late reports than was the staff member who abused the resident and her supervisor who witnessed and had not reported the incident. Certainly, the message sent to those staff members was not to report such incidents. The obvious result of this apparent tolerance of abuse and lack of vigor when investigating such cases is harm to Arlington residents. Because reporting of abuse is discounted by Arlington, staff are not trained in detection of abuse and

independent opinions are not sought to ascertain whether suspicious injuries are the result of abuse.

We have concluded that abuse is occurring at Arlington. Our conclusion that Arlington residents are being abused is not limited to physical abuse. Our investigation revealed that staff at Arlington have verbally abused residents. These actions have apparently also been tolerated or discounted by the administration.

2. Arlington Residents Do Not Receive Adequate Medical Care

a. Failure to adequately diagnose and treat residents.

Our consultants found that Arlington lacks long range planning for managing residents with chronic medical conditions. Routine procedures for testing residents' blood levels and monitoring the course of chronic diseases were not implemented. For example, routine testing of vomitus for blood was not accomplished for a resident who, on numerous occasions, had symptoms of gastric bleeding. Our consultant found that the failure to order such tests substantially departed from accepted medical practice. There were inadequate efforts to diagnose residents' problems, a process essential to appropriate treatment and evaluation of the efficacy of treatment. As a result, residents' physical conditions have deteriorated. In fact, five Arlington residents have died since October 10, 1990. The medical care provided to these residents, three of whom were less than 23 years old, was inadequate. Additionally, Arlington does not have a system to detect the onset of insidious illnesses. Because changes in

residents' physical conditions are not routinely monitored, their conditions may deteriorate and become quite serious before medical treatment is initiated. We have concluded that the care and treatment of residents with chronic conditions substantially departs from accepted medical practice.

Our consultants found that Arlington had no procedures for monitoring the effectiveness of medications prescribed. As a result, residents are not treated for side effects or may continue to receive medications that are not effective and do not resolve their medical conditions. Generally, our consultants found that documentation of medical evaluations and treatment is inadequate, especially for residents with more serious and chronic diseases. Due to a failure to document ongoing health care problems, Arlington does not provide adequate preventative health care. There are also unacceptable delays in placing hospital communications, i.e., discharge summaries and emergency room reports, in residents' charts. Because current and complete medical information is not maintained in the chart, professional and direct care staff lack important information on which to base their judgments and services. This deficiency subjects residents of Arlington to unnecessary risk of harm from inappropriate treatment decisions.

Our consultants found that Arlington does not attempt to diagnose residents' underlying psychiatric disorders and fails to monitor positive and negative effects when psycho tropic medications are prescribed. Some residents receiving psycho tropics do not benefit from them, while others who might benefit do not receive them. Our consultants also found that Arlington automatically reduced or eliminated such medications with inadequate justification. In light of the

above, our consultants concluded that psycho tropic medications are not being prescribed or monitored consistent with professional standards. Because such medications can have a serious deleterious side effects, prescription of the wrong medication and failure to properly monitor them subjects residents to undue risk of harm. Additionally, there is a significant danger that psycho tropic medications may be used as chemical restraints.

Our consultants found that residents are not referred to or seen by consulting physicians as frequently as their conditions require. Specifically, residents with neurological and orthopedic problems and conditions are not identified, managed, evaluated, or treated consistent with the judgment of qualified professionals. Our consultants observed residents having seizures whose seizure activity was not noticed by Arlington's direct care and nursing staff. Such failure to identify and record seizure activity clearly results in harm to these residents. Dramatic evidence of the failure to manage such conditions was the death in December of a resident who had been having numerous seizures and is believed to have died as a result of a seizure. Our expert concluded that the medical care provided this resident was clearly inadequate. The predictable result of these deficiencies in medical care is unnecessary risk of harm to Arlington residents.

b. Failure to provide essential physical therapy services.

After an exhaustive review of the physical therapy services offered at Arlington, our consultant concluded that Arlington is failing to adequately provide such services and that such failure constituted a serious deficiency in residents'

medical care. In a population of approximately 250 physically handicapped residents, none receive hands on therapy from a physical therapist. Moreover, our expert found that residents' physical therapy programs are not individualized and do not address their specific needs. The failure to provide necessary physical therapy services results in contractures, physical degeneration, inappropriate body growth, and deformity that, in turn, subjects residents to eating, digestion, and general medical problems (e.g., respiratory difficulties due to scoliosis). The failure to provide appropriate evaluations, goals, and services often results in physical deterioration. Our consultant found that Arlington's improper positioning of residents has actually increased their deformities. She found that such harm was attributable to both inadequate and inappropriate physical therapy programs and inadequate numbers of adequately trained staff.

Our consultant physical therapist concluded that the use of adaptive equipment at Arlington often does not reflect the exercise of judgment by a qualified professional. Inappropriate use of such equipment jeopardizes the health and safety of residents. Ill-fitting adaptive equipment, including wheelchairs, does not provide adequate support, thereby increasing the risk of accidental injury and physical deterioration. Numerous residents who once sat in wheelchairs are now confined to carts. This is dramatic evidence of such physical deterioration. Our consultant found that the deformities of these cart-bound residents were a result of improper positioning and inadequate physical therapy services. Additionally, the carts themselves are dangerous. Incident reports reviewed during the investigation relfect that a number of residents have been injured when they fell out of

unstable carts. Moreover, our nurse consultant observed that Arlington is not providing adequate assistive devices to enable residents to walk and move. The natural result of the failure to provide such devices is resident injury and physical deterioration.

Arlington is failing to provide physical therapy services and staff to render appropriate and necessary care to address the physical therapy needs of the residents of Arlington and to implement physical therapy services programs consistent with qualified professional judgment. See Youngberg v. Romeo, supra, at 324.

(c) Failure to provide sufficient numbers of appropriately trained staff to render and implement professional judgments regarding necessary medical treatment.

Our investigation revealed that the nursing department is critically short staffed. There are not enough adequately trained nurses at Arlington, a deficiency that places residents at an unreasonable risk of harm. For example, our consultant observed nurses inappropriately dispensing medications to physically handicapped residents, e.g., by means of a tongue blade placed down residents' throats. Our consultant found that this method of medicating physically involved residents may result in harm. Nurses are not promptly hired to replace those that leave. Because of these shortages, nurses often "float" to areas to which they are not typically assigned and where they are responsible for caring for residents with whom they are not familiar. It is not unusual for one nurse, assigned to a unit as a floater, to administer medications to 128 residents twice in one 8 hour shift. The potential for

medication errors in such circumstances is obvious. While Arlington officially reported only two medication errors over a time frame, our consultant' review of residents' records as well as information obtained from other sources suggests that these figures seriously underrepresent the breadth of that problem at Arlington.

At the time of our latest tour, December 1990, there were only three physicians, including the Medical Director, to provide medical care to almost 500 developmentally disabled Arlington residents. Many of these residents have serious physical disabilities and complex medical needs. In our expert's view, three primary care physicians are not sufficient to examine 500 residents, review their charts, adjust their medications, and keep abreast of their medical condition, i.e., to render decisions with respect to care that are consistent with professional judgments. The shortage results in a failure to adequately manage, evaluate, and treat chronic medical conditions.

While Arlington has contracted with a number of specialists to examine and treat its residents, our experts consider that the hours contracted for are not sufficient to provide a level of care consistent with professional standards. For example, Arlington has a contract providing for neurology consultation three times per year. This is not adequate to properly evaluate, treat, and follow the more than 260 residents with seizure disorders. Similarly, of those residents' records that we reviewed, a majority of residents with physical disabilities had not received an orthopedic consultation within the past two years. Our investigation also revealed that necessary orthopedic surgery is not recommended or undertaken because appropriate therapy and

follow-up is not available. In our consultants' opinion, given the serious physical impairments of many of Arlington's residents, this level of consultation and care is seriously inadequate.

As discussed above, there is a critical shortage of physical therapists. There are approximately 250 residents in need of physical therapy services; Arlington contracts with two part-time physical therapists who work a combined total of 28-30 hours per week. Our consultants concluded that 30 hours per week is totally inadequate to provide necessary physical therapy services to all Arlington residents who need them. Additionally, the direct care staff receives no training in physical management and positioning of these physically handicapped residents. Our consultants found that the failure to move, reposition, exercise, and provide hands on physical therapy to such residents leads to physical deterioration and other harm.

Staff at Arlington does not adequately identify or care for residents with impaired eating ability. Staff fail to properly position residents during meals, utilize appropriate feeding techniques, and effectively monitor residents. Because of this, Arlington residents face serious risks of aspiration, a leading cause of death among institutionalized developmentally disabled populations. Our experts personally observed residents coughing and choking on food and mucus during meals. Aspiration pneumonia accounted for at least three of the seven pneumonia-related hospital admissions of Arlington residents in the period from July 1, 1990, to December 15, 1990. One of the five recent deaths of Arlington residents was caused by aspiration pneumonia.

After two of our tours, our consultants requested that we immediately convey to Arlington staff their concern that these conditions were life-threatening to residents. We did so. However, despite the serious risks of aspiration, Arlington fails to ensure that residents are fed safely.

3. Arlington Residents Do Not Receive Adequate Training.

a. Failure to Provide Training Required by Youngberg.

Following a careful review, our consultant psychologist concluded that the lack of training programs for Arlington residents results in injury and the unreasonable risk of injury (to self and others). Instances of self-abuse were not uncommon; observed attempts to intervene appropriately were rare. Many residents were observed to have unexplained cuts, bruises and scrapes. Our expert concluded that the current practice of behavior modification at Arlington fails to reduce aggressive and other maladaptive and inappropriate behavior. Moreover, Arlington does not provide adequate psychological services to children to prevent them from developing self-abusive behaviors. Clearly, many of the injuries we observed may have been preventable had programs been implemented and if more trained staff were available.

As a result of Arlington's continuing failure to design and implement adequate training programs, residents suffer otherwise preventable physical injuries, either self-inflicted or from other residents. Approximately 40% of the injuries in a representative sampling of Arlington residents were reported

as either self-inflicted or caused by other residents. Reducing aggressive and other maladaptive and inappropriate behaviors through appropriate behavior modification and training would significantly reduce such injuries.

Our consultants found that, although the great majority of Arlington's residents are diagnosed as severely or profoundly mentally retarded, many are misdiagnosed. Arlington does not have adequate diagnostic criteria to determine degrees of ability. As a result of inaccurate diagnoses, the meager training provided these residents is inappropriate.

Our investigation also revealed that there are many severely physically handicapped residents who are misdiagnosed as severely or profoundly mentally handicapped because of their physical limitations. As a result of such misdiagnoses, residents do not receive programming that qualified professionals would consider necessary. For example, many such residents are not provided the means to communicate through communication boards or other assistive communication devices even though they are capable of learning such skills that would enable them to communicate their needs, including their needs for specific care or treatment. The failure to provide residents with means to express their needs results in harm and possible injury.

Our experts found that most of the training plans and behavioral programs do not address the individual needs of the residents and often contained inappropriate or incompatible goals. Our expert found identical plans and programs for residents who appeared to be functioning at different levels; additionally, the programs were unchanged

from one year to the next. The lack of individualized programs and the failure to revise and update such programs represent a substantial departure from accepted professional practice.

Arlington residents do not have access to adequate and necessary programs, i.e., work-related, age appropriate fine and gross motor activities, to maintain their current level of functioning. Our consultant found that the dearth of such programs harms residents in two ways. First, because they are not provided with appropriate stimulation, residents may resort to self-abusive or other maladaptive behaviors. Second, in the absence of such programs, deterioration of physical and mental functioning is likely. As a result of this deficiency, residents of Arlington are at a substantial risk of harm.

We additionally found that behavioral records are not maintained and progress data is not collected in a consistent fashion and is not reliable. Inaccurate or incomplete behavioral data collection and recordkeeping present an active danger to residents by depriving professional and other staff of information necessary to make professional, appropriate, and safe decisions regarding training.

b. Inadequate numbers of and insufficiently trained staff to permit the training required by Youngberg.

Our experts concluded that the three full time and two part time (3.5 FTE) psychologists at Arlington — the persons who are responsible for the design, implementation, supervision, and evaluation of training programs to ensure

resident safety and freedom from undue restraint — are clearly inadequate to render professional judgments with respect to the care and training of Arlington residents. Each of these psychologists has a caseload of approximately 140 residents. Our consultant found that a caseload of this size is clearly too large to provide adequate treatment for Arlington residents who require psychological services. Moreover, there are no doctoral level psychologists on staff to supervise other staff functioning as psychologists. An inadequate number of trained psychologists has resulted in a failure to develop consistent and necessary treatment and training programs, to implement and monitor them, and to collect and record accurate and pertinent progress data. As a result, residents are at substantial risk of harm.

The safety of Arlington's residents is endangered by inadequate numbers of insufficiently trained direct care staff. Our investigation found that a majority of day and evening shifts, shifts that are scheduled to have a 1:4 staff to resident ratio, in reality function with a ratio of 8 or more residents for each direct care staff. As a consequence of direct care staff shortages, we observed a widespread failure to appropriately manage maladaptive behavior. In one unit, our consultant observed four resident engaging in self-injurious behavior. No staff members intervened. In another unit, a woman repeatedly banged her face against her arm brace. Once again, no staff intervened.

The direct care staff does not possess the technical competence to adequately supervise and train residents of Arlington. In addition, they were generally unfamiliar with residents' behavior programs. Training given to the staff is insufficient in depth and scope to enable them to adequately

and effectively provide essential care to residents. As a result of inadequate numbers of inadequately trained direct care staff, resident fail to receive adequate daily supervision and training. This failure contributes to an alarmingly high frequency of injuries, 20% of which are of unknown cause. As a consequence of the foregoing, residents of Arlington are exposed to serious risks to their health and safety.

4. Arlington School-Aged Residents Are Not Provided A Free Appropriate Public Education As Required By The Education Of The Handicapped Act

One hundred and sixteen school-aged children reside at Arlington. We have concluded that they are not being provided a free appropriate public education required under the Education of the Handicapped Act, 20 U.S.C. §1400 et seq. (EHA). Specifically, none of these children attend school off the grounds, although a public elementary school is located a very short distance from the facility. Arlington has two educational programs for the children who live at the facility. One group is sent to a building on the grounds where they attend classes; the other, consisting of more medically fragile children, attends classes in the residences. The classroom building has been closed for asbestos removal since August 1990 and had not reopened at the time of our latest tour in December 1990. Therefore, all children have attended classes in their residences thus far in this school year. Under the EHA, handicapped children are required to be provided a free appropriate public education with non-handicapped children whenever possible. This requirement is clearly being violated. Moreover, our review of residents' Individual Education Programs confirms that the number of hours residents attend classes as well as the length of the school year

does not meet the EHA's standards.

5. Arlington Residents Are Not Provided A Safe Environment

Our consultant found a number of serious fire safety hazards at Arlington. He identified a major fire safety hazard in the Baker Building, the building that houses both the Infirmary and Arlington's most physically involved residents. All fire exits lead to a confined passageway that does not have appropriate protections to permit the residents, many of whom are confined to wheelchairs or carts, the time to exit safely in case of a fire. Our investigation revealed that the majority of Arlington's residential units do not meet the level of safety required by professional standards due to structural deficiencies (for example, inadequate partitions), doors that are not fire resistant, failure to provide necessary smoke detectors or sprinklers, or inappropriate storage of combustible materials. As a consequence, residents of Arlington are exposed to serious risks to their health and safety.

Minimally Necessary Remedies

Based upon the circumstances discussed above, we have concluded that Arlington residents are being subjected to egregious or flagrant conditions that deprive them of their constitutional rights pursuant to a pattern and practice of resistance to the full enjoyment of those rights. In order to eliminate the conditions that cause these deprivations, at a minimum, Arlington must implement the following remedies:

1) The State must no abuse or neglect Arlington

residents and must establish a system to assure that allegations of abuse and neglect are investigated thoroughly and that appropriate action, commensurate with the nature of the offense, is taken against anyone who inflicts, condones, or fails to report abuse or neglect.

2) The State must provide adequate medical care to Arlington residents, including identification, treatment, and management of their acute and chronic medical conditions.

3) The State must provide professionally designed feeding programs for the residents at Arlington who need them, and assure that such programs are appropriately implemented by trained staff in order to protect residents from risks of harm, particularly from aspiration pneumonia.

4) The State must identify all residents who need physical therapy and must provide professionally designed physical therapy programs appropriately implemented by trained staff. The State must ensure that adaptive equipment provided to physically handicapped residents is individualized and appropriate and that a qualified professional oversees its design, use, and repair.

5) The State must provide professionally designed training programs to the residents at Arlington who need them and for whom training will reduce or eliminate unreasonable risks to their personal safety and/or the need to use undue bodily and chemical

restraints, and must ensure that such programs are implemented by trained staff. Immediate attention must be given to residents with self-injurious, physically abusive and other destructive behaviors by identifying them and providing necessary training on a priority basis.

6) The State must hire, deploy, and provide ongoing training to a sufficient number of competent and qualified direct care and professional staff to provide residents at Arlington with adequate medical treatment, physical therapy, physical management and positioning, and training programs. Particular attention should be given to ensuring that professional staff receive continuing medical education so that they are equipped to provide adequate long-term care for medical problems commonly found in residents living in facilities for the mentally retarded.

7) The State must hire or contract for the services of sufficient physicians to provide residents with adequate medical and psychiatric services.

8) The State must assure that school-aged children receive a free appropriate public education, including mainstreaming for those children who are capable of attending school off grounds. Children who attend school at Arlington must be provided a professionally designed individualized education program suited to their needs, and one that provides each student with an appropriate length of school day and school year.

9) The State must remove fire hazards and make

appropriate renovations to protect the safety of Arlington residents.

10) The State must assure that Arlington develops and implements recordkeeping systems to monitor the use and effectiveness of behavior and other programs and training, and the use of medications, and ensure periodic re-evaluations of such use.

To rectify the deficiencies at Arlington and to ensure that constitutionally adequate conditions are maintained thereafter, we propose to negotiate an agreement with the State of Tennessee, to be entered as an order of a federal court, which shall provide, at a minimum, that the above referenced remedies will be implemented at Arlington.

Information about Federal financial assistance which may be available to assist with the remedial process can be obtained through the United States Department of Health and Human Services' Regional Office (Director, Intergovernmental and Congressional Affairs), and through appropriate officials of the United States Department of Education.

Our attorneys will be contacting legal counsel for the Tennessee Department of Mental Health and Mental Retardation shortly to arrange a meeting to discuss this matter in greater detail. In the meantime, should you or your staff have any questions regarding this matter, please feel free to call Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255. To date, we have been able to conduct this investigation in the spirit of cooperation intended by the Civil Rights of Institutionalized Persons Act, and look

forward to continuing to work in the same manner with State officials toward an amicable resolution of this matter.

Sincerely,

/s/_____
John R. Dunne
Assistant Attorney General
Civil Rights Division

APPENDIX T

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

PEOPLE FIRST OF TENNESSEE, on behalf of its members, Plaintiffs,	)	) Civil No. 92-2213-ML-B
v.	)	
THE ARLINGTON DEVELOPMENTAL CENTER, et al., Defendants,	)	
PARENT-GUARDIAN ASSOCIATION OF ARLINGTON DEVELOPMENTAL CENTER, Defendant-Intervenor.	)	

STIPULATION OF VOLUNTARY DISMISSAL OF TWO CLAIMS FOR RELIEF

The parties to this action, pursuant to Rule 41(a) of the Federal Rules of Civil Procedure, hereby stipulate to a voluntary dismissal of two claims for relief alleged by plaintiffs in this action, to wit: their claims based upon violation of plaintiffs' EQUAL PROTECTION AND

PROCEDURAL DUE PROCESS rights.

This 9 day of May, 1994.

(Signatures appear on the following page)

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/s/_____
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